Original

Sumner Regional Medical Center Satellite ED

CN1508-029

SUMNER
Regional Medical Center
HIGHPOINT HEALTH SYSTEM

SATELLITE EMERGENCY DEPARTMENT AT SUMNER STATION IN GALLATIN, SUMNER COUNTY

CERTIFICATE OF NEED APPLICATION
AUGUST 2015

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A."* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** *certificate of corporate existence, if applicable, from the Tennessee Secretary of State.*

For Section A, Item 4, *Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

1.	***Name of Facility, Agency, or Institution***			
	Sumner Regional Medical Center (for its Sumner Station Campus)			
	Name			
	225 Big Station Camp Boulevard	Sumner		
	Street or Route	County		
	Gallatin	Tennessee	37066	
	City	State	Zip Code	

2.	***Contact Person Available for Responses to Questions***				
	Michael Herman		Chief Operating Officer		
	Name		Title		
	Sumner Regional Medical Center		Michael.Herman@LPNT.net		
	Company Name		Email address		
	555 Hartsville Pike	Gallatin	Tennessee	37066	
	Street or Route	City	State	Zip Code	
	Chief Operating Officer		615-328-6695	615-328-6698	
	Association with Owner		Phone Number	Fax Number	

3.	***Owner of the Facility, Agency or Institution***		
	Sumner Regional Medical Center, LLC		615-328-6695
	Name		Phone Number
	330 Seven Springs Way		Sumner
	Street or Route		County
	Brentwood	Tennessee	37027
	City	State	Zip Code

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	______	F.	Governmental (State of TN or Political Subdivision)	______
B.	Partnership	______	G.	Joint Venture	______
C.	Limited Partnership	______	H.	Limited Liability Company	X
D.	Corporation (For Profit)	______	I.	Other (Specify)__________	______
E.	Corporation (Not-for-Profit)	______			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. ***Name of Management/Operating Entity (If Applicable)***

N/A
Name

Street or Route | County

City | ST | Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D.	Option to Lease	___
B.	Option to Purchase	___	E.	Other (Specify) ___	___
C.	Lease of __ Years	___			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) Acute Care	X	I.	Nursing Home	___
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	___	J.	Outpatient Diagnostic Center	___
C.	ASTC, Single Specialty	___	K.	Recuperation Center	___
D.	Home Health Agency	___	L.	Rehabilitation Facility	___
E.	Hospice	___	M.	Residential Hospice	___
F.	Mental Health Hospital	___	N.	Non-Residential Methadone Facility	___
G.	Mental Health Residential Treatment Facility	___	O.	Birthing Center	___
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)	___	P.	Other Outpatient Facility (Specify) Satellite ED	X
			Q.	Other (Specify) ___	___

8. **Purpose of Review** ***(Check as appropriate--more than one response may apply)***

A.	New Institution	___	G.	Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	___
B.	Replacement/Existing Facility	___	H.	Change of Location	___
C.	Modification/Existing Facility	___	I.	Other (Specify) Add Satellite Emergency Department	X
D.	Initiation of Significant Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Emergency Dept	X			
E.	Discontinuance of OB Services	___			
F	Acquisition of Equipment	___			

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical (General Med/Surg)	90	0	90	0	90
C.	Long-Term Care Hospital					
D.	Obstetrical	15	0	15	0	15
E.	ICU/CCU	18	0	18	0	18
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric	12		12		12
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation	20		20		20
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	155	0	155	0	155

*CON-Beds approved but not yet in service

10. Medicare Provider Number 1447571658

Certification Type Acute Care Hospital

11. Medicaid Provider Number 044-0003

Certification Type Acute Care Hospital

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? N/A

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** **Yes** **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or *plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE: Sumner Regional Medical Center ("SRMC") participates in the major TennCare MCOs serving the majority of the patients in the area: UnitedHealthcare, Amerigroup, TennCare Select, and BlueCare. In total, SRMC participates in approximately 34 managed care organizations/behavioral health organizations. Please see **Attachment A,13 (Tab 6)** for a list of managed care contracts in which SRMC participates.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE: Please see the following executive summary.

CREATE A SATELLITE EMERGENCY DEPARTMENT ("ED") IN GALLATIN, SUMNER CO., AT SRMC'S SUMNER STATION CAMPUS

APPLICANT OVERVIEW: Sumner Regional Medical Center ("SRMC") is a 155-bed acute care hospital in Gallatin, Tennessee. It is part of LifePoint Hospitals. LifePoint Hospitals is headquartered in Brentwood, Tennessee. It operates 63 hospitals in 20 states, including 10 in Tennessee. SRMC is one of 15 LifePoint hospitals that was recognized by the Joint Commission in 2013 as a Top Performer in Key Quality Measures.

With this project, Sumner Regional Medical Center proposes to initiate a Satellite Emergency Department ("ED") at its existing outpatient campus, known as "Sumner Station," located on Big Station Camp Boulevard just off Vietnam Veterans Parkway, approximately 6.9 miles west of the main campus. Due to area traffic patterns, easily accessible emergency services are currently not available to large portions of the community. The availability of the satellite ED service at Sumner Station will alleviate the travel for these patients and improve accessibility to life-saving care.

EXISTING RESOURCES. SRMC's Emergency Department is a full-service ED that serves the surrounding community. The ED is staffed with board-certified emergency medicine physicians and experienced registered nurses that provide patients immediate access to the most advanced diagnostic services and lifesaving care available.

SRMC's emergency services include an accredited Chest Pain Center, as well as a vast array treatment options for illnesses and injuries. Whether a patient has an emergency, accident or suffers a traumatic injury, SRMC provides holistic care for the body, mind and spirit.

SRMC's ED provides advanced care 24 hours a day, seven days a week with several notable designations:

- Dedicated Chest Pain Center by the Society of Cardiovascular Patient Care
- On call 24 / 7 / 365 Cardiac Interventionalist Physician
- On call 24 / 7 / 365 Primary Pediatrics Care

In Gallatin, adjacent to the proposed Satellite ED in the Sumner Station complex, SRMC operates a full-service imaging center that provides X-ray, ultrasound, CT, MRI, bone densitometry, cardiac calcium scoring CT, coronary CTA, lung screening CT, mammography, PAD screening, and wellness imaging. Recent additions to the Sumner Station campus include the relocation of radiation therapy services from the main hospital campus, and the addition of PET/CT scanning services. Both of these recent additions are currently in the process of being implemented. When fully operational, this wide range of complementary services will allow the Sumner Station facility to function as a Cancer Center, providing diagnosis, treatment, and social support to cancer patients and their families.

PROPOSED SERVICES AND EQUIPMENT: SRMC is not proposing any new services or CON reviewable equipment. As described more fully in the need section below, this project is to add four[1] Satellite Emergency Department treatment rooms at its Sumner Station campus in Gallatin, to the existing 26 emergency treatment rooms at SRMC's main campus. 24/7 imaging services will be provided by SRMC's on-site full-service imaging center.

OWNERSHIP STRUCTURE: SRMC is part of LifePoint Hospitals. LifePoint Hospitals is headquartered in Brentwood, Tennessee. It operates 63 hospitals in 20 states, including 10 in Tennessee. The proposed project will not result in a change in ownership structure.

SERVICE AREA: Based on historical patient origin data and area driving distances/times, SRMC's service area for this Satellite ED project is comprised of two zip codes in Sumner County - 37066 and 37075.

NEED: The proposed Satellite ED is in full alignment with SRMC's long term mission of making its local community healthier. Rather than traveling to downtown Gallatin, this project brings convenient, accessible healthcare services to the local community so patients can receive healthcare closer to where they live and work. SRMC currently serves approximately 38,000 emergency department patients annually with 26 treatment rooms (3 rooms were added in 2014). Planning guidelines from the American College of Emergency Physicians ("ACEP") recommend 1,500 patients per emergency treatment room per year. At this level, SRMC operated at or above 100% capacity for the last three years. Due to facility constraints at the main campus, additional ED expansion into adjacent space is not practical. Off-site expansion at Sumner Station is a logical alternative.

Specific needs include:

- Better meet community demand for emergency services – Population based ED use rate analyses in the service area indicate an increasing demand for emergency room services over the next five years. Based on the ACEP standard of 1,500 visits per emergency treatment room per year, projected incremental volumes in the service area are sufficient to support 10 emergency treatment rooms at 100% utilization or 14 emergency treatment rooms at 70% utilization. These treatment room projections would not take any patients away from existing providers and do not consider in-migration from the surrounding counties.

- Reduce high utilization of existing ED treatment rooms – SRMC has a very active emergency service today, with utilization often exceeding 100%. By the nature of the facility layout, SRMC is unable to expand ED services at the main hospital. This proposed satellite ED location will better distribute vital resources throughout the service area.

[1] Four rooms are proposed in Year 1, adding a fifth room in Year 2 as the demand for services increases.

- Improve patient flow and operational efficiency – By adding ED capacity to the healthcare delivery system, this satellite ED project will help improve patient treatment times for Sumner County residents whether they seek care locally or now travel to SRMC's main campus.

- Improve quality of care – With emergency services, every minute counts. SRMC and its emergency services team members seek to bring their experience and expertise closer to the patient in order to improve the patient experience and outcomes.

- Meet the needs of an aging population – Between 2015 and 2020, the Sumner County 65 and older population is projected to increase by 22.3%. This is much higher than the statewide growth projection of 15.4%, and indicates a likely increase in demand for emergency services.

Regardless of the incremental need detailed above, SRMC has based its need projections exclusively on the redirection of its own existing patients from the highly utilized SRMC main campus to the proposed Sumner Station satellite ED facility. Through this patient redirection, SRMC can achieve its projected patient volumes based on its own existing patients, with little or no adverse impact on existing providers.

PROJECT COST: The total estimated cost of the proposed project is $5,603,276. Project costs include $2,940,000 for renovations of 10,210 square feet of space. Renovation cost per square foot is $288. The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

FUNDING: SRMC will receive funding for the project by a capital contribution from the applicant's parent, LifePoint Hospitals.

FINANCIAL FEASIBILITY: SRMC expects that construction will be completed and the project will be operational by July 2017. Projections for Year 1 and Year 2 indicate that the project is financially feasible. As explained below, this project is being proposed in order to improve access to care and quality of care without increasing charges to government and third-party payors.

STAFFING: This project will be staffed with the assistance of the 4.2 existing board-certified emergency medicine physicians now providing services at SRMC. This project will result in 41.9 FTEs in total staff. SRMC's salaries and wages are competitive with the market area. SRMC has a history of successfully recruiting and retaining professional and administrative staff.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: This project involves renovation of 10,210 square feet of existing shelled space at the Sumner Station outpatient facility. Four emergency department treatment rooms will be created and used in year one of the project, with shelled space for a fifth room, to be opened in year two of the project as the demand for services increases.

The total estimated cost of the proposed project is $5,603,276. Project costs include $2,940,000 for the renovation of 10,210 square feet of existing space. Renovation cost per square foot is $288. The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

No temporary relocation is required.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: Not applicable. The proposed project does not affect the total bed complement at the hospital.

Square Footage Exhibit

A. Unit/Department	Existing Location	Existing Sq. Ft.	Temporary Location	Proposed Final Location	Proposed Final Sq. Footage			Proposed Final Cost/Sq. Ft.		
					Renovated	New	Total	Renovated	New	Total
Satellite Emergency Department	N/A	N/A	N/A	Sumner Station	10,210	N/A	10,210	$288	N/A	$288
B. Unit/Dept GSF Sub-Total	**N/A**	**N/A**	**N/A**	**Sumner Station**	**10,210**	**N/A**	**10,210**	**$288**	**N/A**	**$288**
C. Mechanical/Electrical GSF	**N/A**	**N/A**	**N/A**	**Sumner Station**	**Included**	**N/A**			**N/A**	
D. Circulation/Structure GSF	**N/A**	**N/A**	**N/A**	**Sumner Station**	**Included**	**N/A**			**N/A**	
E. Total GSF	**N/A**	**N/A**	**N/A**	**Sumner Station**	**10,210**	**N/A**	**10,210**	**$288**	**N/A**	**$288**

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: Not applicable. SRMC is not requesting new services or additional pieces of major medical equipment.

D. Describe the need to change location or replace an existing facility.

RESPONSE: This project involves the expansion of SRMC's existing emergency department services to a second location in Gallatin, Sumner County. It is expected to serve patients primarily from Sumner County.

SRMC added 3 treatment rooms in 2014. Renovating and enlarging the existing emergency department at Sumner Regional Medical Center is not a viable option. The emergency department at SRMC is located in a basement area, and due to the facility layout, is unable to expand further. To attempt to do so would be cost prohibitive. As SRMC's campus has become increasingly crowded, the hospital has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities, specifically at Sumner Station. This is evidenced generally by the development of outpatient diagnostic services.

Emergency services are an essential hospital responsibility to the community. This proposal will enhance SRMC's current service line by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Gallatin. Second, it will bring services closer to the communities where SRMC's patients now work and reside. This is vitally important for emergency services where every minute counts.

With regard to this particular project, SRMC already owns the shelled space for the proposed emergency department at its Sumner Station outpatient facility. This will allow the project to be completed exclusively in renovated space, a much more cost efficient option than new construction. Additionally, Sumner Station already operates a full service imaging center that will be utilized by the proposed emergency department, saving millions of dollars in duplicate equipment and construction costs.

Thus, this project addresses the site deficiency at SRMC's existing in-town campus and does so in a cost-effective approach by leveraging existing imaging services in Gallatin.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:
      1. Total cost; (As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.

   b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable, as SRMC is not proposing to acquire any single piece of major medical equipment that exceeds $1.5 million or is a MRI, PET, extracorporeal lithotripter or linear accelerator.

2. For mobile major medical equipment:

   a. List all sites that will be served;
   b. Provide current and/or proposed schedule of operations;
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment; and
   e. List the owner for the equipment.

RESPONSE: Not applicable. No major mobile equipment is proposed.

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable. No major equipment is proposed.

III. **(A)** Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE: Please see **Attachment B, III.(A) (Tab 7)** that depicts the 24.57-acre site.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

RESPONSE: Sumner Station is located on Big Station Camp Boulevard, between Long Hollow Pike and the Vietnam Veterans Bypass. There is not direct bus service to the facility, but Sumner Station is easily accessible by car. Additionally, Mid-Cumberland Human Resources Agency RTS Public Transit serves the area.

Please see **Attachment B, III.(B).1 (Tab 8)** for a map depicting the service area and the thoroughfares that connect local residents to the proposed site. Also included is a drive-time study map that details the patient origin of SRMC's actual 2014 ED patients, color coded by the shortest travel time to receive service (Main campus ED versus the proposed Sumner Station satellite ED). As depicted on the map, the Sumner Station satellite ED will greatly improve access for many of SRMC's existing patients residing in the proposed service area.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE: Please see **Attachment B, IV (Tab 9)** for the floor plan schematics.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE: Not applicable. The project does not involve a Home Health Agency or Hospice.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

    a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

    RESPONSE: One category is applicable to the project and is addressed below.

    CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

    1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

        RESPONSE: Not applicable. The SRMC Satellite ED project does not include the addition of beds, services or medical equipment.

    2. For relocation or replacement of an existing licensed health care institution:

        a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

        b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

        RESPONSE: Not applicable. The SRMC Satellite ED project does not include the relocation or replacement of an existing licensed health care institution.

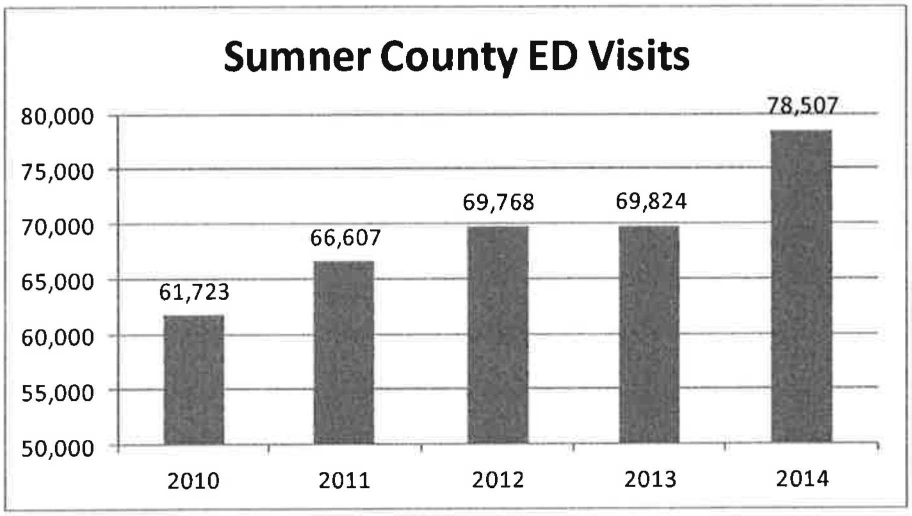
3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

RESPONSE: As illustrated below, Tennessee Hospital Association patient origin data indicate that emergency department visits have increased significantly throughout the proposed service area the past five years from 2010 to 2014.

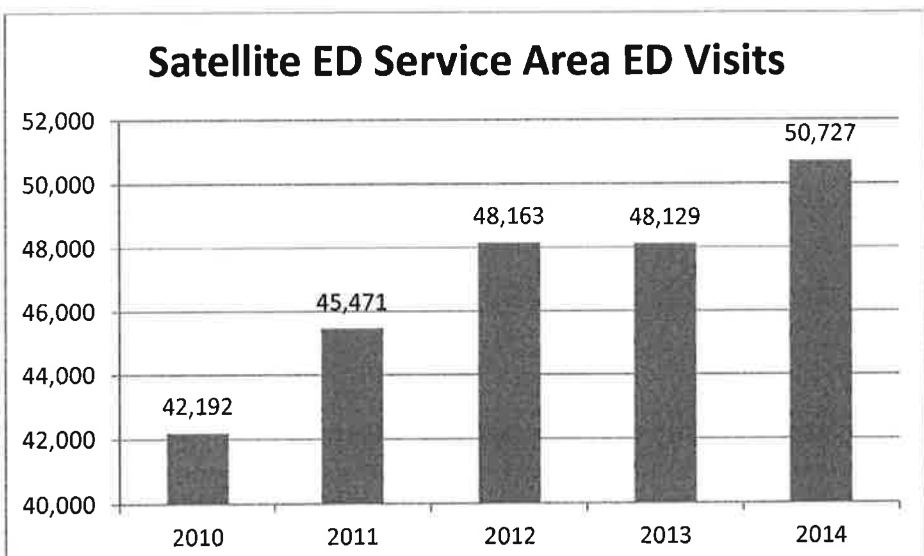
- Sumner County – 16,784 visits or 27.2% growth
- 2 Zip Code Area – 8,535 visits or 20.2% growth

Exhibit 1



Source: Tennessee Hospital Association patient origin data

Exhibit 2



Source: Tennessee Hospital Association patient origin data
Note: Includes two zip codes: 37066 and 37075

This robust growth in emergency department visits is projected to continue the next five years as well, from 2015 to 2020.

Based upon age cohort ED use rates for 2014, utilization within Sumner County is far lower than that within the adjacent counties of Davidson, Macon, Robertson, and Trousdale, as well as for the state of Tennessee overall.

Exhibit 3

ER Visits per 1,000 Population in Sumner County and Surrounding Areas

ER Visits by County and Age Cohort, 2014

Patient County	0-19	20-44	45-64	65+	Total
Davidson	73,738	141,062	78,478	42,017	335,295
Macon	2,486	4,306	2,584	1,972	11,348
Robertson	8,098	13,666	8,586	6,021	36,371
Sumner	*16,665*	*31,818*	*17,024*	*12,999*	*78,506*
Trousdale	1,149	2,243	1,456	831	5,679
Wilson	9,236	17,481	10,463	8,156	45,336
Total	**111,372**	**210,576**	**118,591**	**71,996**	**512,535**
Tennessee	722,107	1,268,019	772,137	555,248	3,317,511

Population by County and Age Cohort, 2014

Patient County	0-19	20-44	45-64	65+	Total
Davidson	169,896	265,210	153,876	73,129	662,111
Macon	6,179	6,855	6,298	3,709	23,041
Robertson	19,941	21,908	19,761	9,621	71,231
Sumner	*47,036*	*52,116*	*48,470*	*24,955*	*172,577*
Trousdale	2,161	2,433	2,369	1,257	8,220
Wilson	33,350	36,443	36,372	17,773	123,938
Total	**278,563**	**384,965**	**267,146**	**130,444**	**1,061,118**
Tennessee	1,732,546	2,140,276	1,771,822	1,008,646	6,653,290

ER Visits per 1,000 Population by County and Age Cohort, 2014

Patient County	0-19	20-44	45-64	65+	Total
Davidson	434.0	531.9	510.0	574.6	506.4
Macon	402.3	628.2	410.3	531.7	492.5
Robertson	406.1	623.8	434.5	625.8	510.6
Sumner	*354.3*	*610.5*	*351.2*	*520.9*	*454.9*
Trousdale	531.7	921.9	614.6	661.1	690.9
Wilson	276.9	479.7	287.7	458.9	365.8
Total	**399.8**	**547.0**	**443.9**	**551.9**	**483.0**
Tennessee	416.8	592.5	435.8	550.5	498.6

Sources: The Tennessee Center for Business and Economic Research (CBER) Population Projections; THA MarketIQ Database 2014 data

Applying the age cohort ED use rates for 2014 to the 2020 projected population suggests that emergency department visits will continue to increase significantly in Sumner County over the next five years from 2015 to 2020, growing by 6,898 visits or 8.6%.

Applying the Tennessee age cohort ED use rates for 2014 to the 2020 projected Sumner County population suggests even stronger projected growth – 14,442 additional visits. This reflects the disparity of current ED use rates within Sumner County compared to the surrounding counties and the state of Tennessee overall.

Based on a standard of 1,500 visits per emergency treatment room per year from the American College of Emergency Physicians, this incremental volume alone is sufficient to support 10 emergency treatment rooms at 100% utilization or 14 emergency treatment rooms at 70% utilization. These treatment room projections would not take any patients away from existing providers and do not consider in-migration from the surrounding counties.

Please see Exhibit 4 below for the analysis detailing the projected growth in ED visits in Sumner County.

Exhibit 4

Projected Growth in ER Visits in Sumner County

Projected ER Visits Sumner County, 2015 (at 2014 actual county Visits/1,000 rates)

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	
Patient County	**2015 Pop**	**Visits/1,000**	**Proj Visits**	**2015 Pop**	**Visits/1,000**	**Proj Visits**	**2015 Pop**	**Visits/1,000**	**Proj Visits**	**2015 Pop**	**Visits/1,000**	**Proj Visits**	**2015 Pop**	**Proj Visits**
Sumner	47,676	354.3	16,892	52,370	610.5	31,973	49,459	351.2	17,371	26,289	520.9	13,694	175,794	79,930

Projected ER Visits for Sumner County, 2020 (at 2014 actual county Visits/1,000 rates)

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	
Patient County	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Proj Visits**
Sumner	49,309	354.3	17,470	55,018	610.5	33,590	53,015	351.2	18,620	32,919	520.9	17,147	190,261	86,828
Sumner at TN Use Rate	*49,309*	*416.8*	*20,551*	*55,018*	*592.5*	*32,596*	*53,015*	*435.8*	*23,103*	*32,919*	*550.5*	*18,122*	*190,261*	*94,372*

Change in Projected Population and ER Visits for Sumner County, 2015 - 2020

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	
Patient County	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Visits/1,000**	**Proj Visits**	**2020 Pop**	**Proj Visits**
Sumner	1,633		579	2,648		1,617	3,556		1,249	6,630		3,454	14,467	6,898
Sumner at TN Use Rate	*1,633*		*3,660*	*2,648*		*623*	*3,556*		*5,732*	*6,630*		*4,428*	*14,467*	*14,442*

Percent Change in Projected Population and ER Visits for Sumner County, 2015 - 2020

	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total		Proj Visits
Patient County	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Visits/1,000**	**Proj Visits**	**Proj Pop**	**Proj Visits**	**Proj Visits**
Sumner	3.4%		3.4%	5.1%		5.1%	7.2%		7.2%	25.2%		25.2%	8.2%	8.6%	1.7%
Sumner at TN Use Rate	*3.4%*		*21.7%*	*5.1%*		*1.9%*	*7.2%*		*33.0%*	*25.2%*		*32.3%*	*8.2%*	*18.1%*	3.4%

Sources: The Tennessee Center for Business and Economic Research (CBER) Population Projections; THA MarketIQ Database 2014 data

The proposed two zip code service area represents a high growth area within Sumner County. As displayed in Exhibit 2, since 2010, ED visits in two zip area have grown by 4.7% per year, from 42,192 ED visits in 2010, to 50,727 visits in 2014. The area has a 2014 population of approximately 108,750[2] residents, which results in an actual ED use rate per 1,000 residents of 466.45. This is slightly higher than Sumner County's actual 2014 use rate of 454.9. However, to be conservative, ED visits are projected to increase from 2015 to 2020 at the same rate as Sumner County overall – 1.7% per year. As illustrated below, this is an increase of 5,399 visits.

Exhibit 5
2 Zip Code Service Area ED Visit Projections
With Increase From 2014 Baseline

Actual 2014	Projected 2015	Projected 2016	Year 1 2017	Year 2 2018	Year 3 2019	Year 4 2020
50,727	51,589	52,466	53,358	54,265	55,188	56,126
--	862	1,739	2,631	3,538	4,461	5,399

Based on a standard of 1,500 visits per treatment room per year from the American College of Emergency Physicians, this volume alone is sufficient to support four emergency treatment rooms at 100% utilization or six emergency treatment rooms at 70% utilization. These treatment room projections would not take any patients away from existing providers and do not consider in-migration from surrounding areas such as other portions of Sumner County.

In summary, depending on assumptions, population growth alone from 2015 to 2020 is expected to generate demand for an additional five to 14 emergency treatment rooms in Sumner County, four to six of which are required in the proposed two zip code satellite ED service area. These are incremental emergency treatment rooms, and thus would have no effect on the utilization rates of existing providers in the service area.

That said, SRMC's satellite ED need methodology assumptions propose strictly to redirect its own existing patients from the SRMC main campus to the proposed Sumner Station satellite ED facility, with absolutely no impact on outside providers.

SRMC's Redirection Plan

Exhibit 6 below details actual ED visits at the SRMC main campus from 2010 to 2015 (3.6%), as well as projected visits through 2020 based on historical annual ED growth experienced at SRMC of roughly 3.5%[3]. The analysis projects growth at the SRMC main campus before any patient redirection to the proposed Sumner Station satellite ED facility, and does so on a calendar year basis[4]. Additionally, the analysis depicts utilization rates both at the ACEP standard of 1,500 visits per emergency treatment room per year, as well as the more conservative 1,800 visits per emergency treatment room per year, the level often used as an internal efficiency benchmark by SRMC.

[2] Nielsen Claritas, Inc.
[3]This level of growth (3.5%) is consistent with the Sumner County annual growth rate experienced in Exhibit 4 when the State of Tennessee visits/1,000 use rates are applied (3.4%).
[4]As Year 1 of the project begins in July 2017, and Year 2 begins in July 2018, at the conclusion of the analysis an adjustment is made to the projections to account for this shift in project timing.

Exhibit 6
SRMC Main Campus ED Visits Before Any Patient Redirection to Sumner Station

	Total SRMC Main Campus ED Visits										
	Actual						Projected (Before Redirection)				
	2010	2011	2012	2013	2014	*2015	2016	2017	2018	2019	2020
Rooms	23	23	23	23	26	26	26	26	26	26	26
ED Visits	31,781	35,453	37,404	38,406	37,147	37,838	39,162	40,533	41,952	43,420	44,940
Annual % Growth	3.55%						3.50%				
Visits/Room	1,382	1,541	1,626	1,670	1,429	1,455	1,506	1,559	1,614	1,670	1,728
Utilization @ 1,500	92.1%	102.8%	108.4%	111.3%	95.2%	97.0%	100.4%	103.9%	107.6%	111.3%	115.2%
Utilization @ 1,800	76.8%	85.6%	90.3%	92.8%	79.4%	80.9%	83.7%	86.6%	89.6%	92.8%	96.0%

* Annualized through June
Source: Internal Data

Exhibit 7 below details actual ED visits at the SRMC main campus originating from the two service area zip codes (37066, and 37075) from 2010 to 2015. Since 2010, the two zip area has experienced an annual growth rate of 6.33%. However, to be conservative the analysis projects the zip code service area growth at 3.5% annually through 2020, the same growth rate experienced hospital-wide as in Exhibit 6 above.

Exhibit 7
SRMC 2-Zip code Service Area ED Visit Projections

	SRMC 2-Zip Code Service Area ED Visits										
	Actual						Projected				
Zip Code	**2010**	**2011**	**2012**	**2013**	**2014**	***2015**	**2016**	**2017**	**2018**	**2019**	**2020**
37066	15,366	17,369	18,628	18,969	20,293	21,003	21,738	22,499	23,286	24,101	24,945
37075	928	1,036	1,058	1,109	1,105	1,144	1,184	1,225	1,268	1,313	1,359
Total	**16,294**	**18,405**	**19,686**	**20,078**	**21,398**	**22,147**	**22,922**	**23,724**	**24,555**	**25,414**	**26,304**
Annual % Growth	6.33%						3.50%				

* Annualized though June
Source: Internal Data

Exhibit 8 then takes the zip code level volumes projected for 2016 through 2020 in Exhibit 7 above, and applies a "redirection percentage", by zip code, to determine the number of visits that SRMC expects to redirect from its main campus to the Sumner Station satellite ED. For zip code 37066, the applicant assumes that it will redirect 20% of its existing visits. For zip code, 37075, SRMC assumes that it will redirect 75% of its existing visits.

SRMC believes that these redirection percentages will be achieved by offering local residents the same level and quality of ED services they now receive, but closer to home and in newer facilities. In some cases, existing SRMC ED patients are now by-passing Sumner Station to receive treatment at the main campus.

The applicant then applied a 5% in-migration factor to the results to account for patients from outside of the service area coming to the facility for care. These steps resulted in the expected total number of visits at Sumner Station. In CY2017, this amounted to 5,690 visits, growing to 6,308 visits by 2020

Exhibit 8
ED Visits Redirected from SRMC's Main Campus to the Satellite ED Facility
2017-2020

	SRMC 2-Zip Code Service Area ED Visits					Redirection Percentage	Visits Redirected to Sumner Station Satellite ED				
	Projected						Projected				
Zip Code	2016	2017	2018	2019	2020		2016	2017	2018	2019	2020
37066	21,738	22,499	23,286	24,101	24,945	20%	4,348	4,500	4,657	4,820	4,989
37075	1,184	1,225	1,268	1,313	1,359	75%	888	919	951	985	1,019
Total	**22,922**	**23,724**	**24,555**	**25,414**	**26,304**		**5,236**	**5,419**	**5,609**	**5,805**	**6,008**
						In-Migration (5%)		271	280	290	300
						Total Visits at Sumner Station		**5,690**	**5,889**	**6,095**	**6,308**

Source: Internal Data

Exhibit 9 below depicts 1) these projected redirected visits to Sumner Station, 2) the resulting effect on the SRMC main campus after this patient redirection, and 3) the results of SRMC's combined ED services volumes at both the main campus, and at Sumner Station. Again, utilization metrics are included for both the ACEP standard of 1,500 visits per emergency treatment room, per year, as well as the more conservative 1,800 visits per emergency treatment room, per year.

Exhibit 9
Projected ED Visits at Sumner Station, Main Campus, and Combined
2017-2020

	Sumner Station ED Visits			
	2017	2018	2019	2020
Rooms	4	5	5	5
ED Visits	5,690	5,889	6,095	6,308
Visits/Room	1,422	1,178	1,219	1,262
Utilization @ 1,500	94.8%	78.5%	81.3%	84.1%
Utilization @ 1,800	79.0%	65.4%	67.7%	70.1%

	SRMC Main Campus ED Visits (After Redirection)			
	2017	2018	2019	2020
Rooms	26	26	26	26
ED Visits	34,843	36,063	37,325	38,631
Visits/Room	1,340	1,387	1,436	1,486
Utilization @ 1,500	89.3%	92.5%	95.7%	99.1%
Utilization @ 1,800	74.5%	77.1%	79.8%	82.5%

	Total SRMC ED Visits, Main Campus and Sumner Station			
	2017	2018	2019	2020
Rooms	30	31	31	31
ED Visits	40,533	41,952	43,420	44,940
Visits/Room	1,351	1,353	1,401	1,450
Utilization @ 1,500	90.1%	90.2%	93.4%	96.6%
Utilization @ 1,800	75.1%	75.2%	77.8%	80.5%

Source: Internal Data

As shown above, even at the higher utilization standard of 1,800 visits per treatment room, Sumner Station is expected to reach 70% utilization by 2020. Similarly, it is expected that SRMC's combined ED services will remain well over 70% utilization, exceeding 80% by 2020.

Exhibit 10 below shifts the projections to match the project timeline, with ED services at Sumner Station commencing in July 2017.

Exhibit 10
Projected ED Visits at Sumner Station, Main Campus, and Combined
2017-2020

Sumner Station ED Visits		
	Year 1	**Year 2**
	7/2017 - 6/2018	**7/2018 - 6/2019**
Rooms	4	5
ED Visits	5,789	5,992
Visits/Room	1,447	1,198
Utilization @ 1,500	96.5%	79.9%
Utilization @ 1,800	80.4%	66.6%

SRMC Main Campus ED Visits (After Redirection)		
	Year 1	**Year 2**
	7/2017 - 6/2018	**7/2018 - 6/2019**
Rooms	26	26
ED Visits	35,453	36,694
Visits/Room	1,364	1,411
Utilization @ 1,500	90.9%	94.1%
Utilization @ 1,800	75.8%	78.4%

Total SRMC ED Visits, Main Campus and Sumner Station		
	Year 1	**Year 2**
	7/2017 - 6/2018	**7/2018 - 6/2019**
Rooms	30	31
ED Visits	41,242	42,686
Visits/Room	1,375	1,377
Utilization @ 1,500	91.6%	91.8%
Utilization @ 1,800	76.4%	76.5%

Source: Internal Data

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

RESPONSE: Three treatment rooms were added in 2014. Renovating and enlarging the existing emergency department at Sumner Regional Medical Center any further is not a viable option. The emergency department at SRMC is located in a basement area, and due to the facility layout, is unable to expand. To attempt to do so would be cost prohibitive. As SRMC's campus has become increasingly crowded, the hospital has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities, specifically at Sumner Station. This is evidenced generally by the development of outpatient diagnostic services and cancer services.

Emergency services are an essential hospital responsibility to the community. This proposal will enhance SRMC's current service line by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Gallatin. Second, it will bring services closer to the communities where SRMC's patients now work and reside. This is vitally important for emergency services where every minute counts.

With regard to this particular project, SRMC already owns the shelled space for the proposed emergency department, its Sumner Station outpatient facility. This will allow the project to be completed exclusively in renovated space, a much more cost efficient option than new construction. Additionally, Sumner Station already operates a full service imaging center that will be utilized by the proposed emergency department, thus saving millions of dollars in duplicate equipment and construction costs.

Thus, this project addresses the site deficiency at SRMC's existing in-town campus and does so in a cost-effective approach by leveraging existing imaging services in Gallatin.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

RESPONSE: Not applicable. This project does not include a change of site for a health care institution but rather a second, satellite location.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

RESPONSE: Sumner Regional Medical Center (SRMC) has been providing quality health care to Gallatin, Hendersonville and the surrounding areas for more than 50 years. Routine facility planning and refurbishment is a necessary part of maintaining quality hospital services. This is especially critical in such key service lines as emergency care.

SRMC's long-range plan includes the intention to maintain and upgrade services and technology to meet community expectations for modern health care. The proposed Satellite ED brings convenient, accessible healthcare services to the local community so patients can receive healthcare closer to where they live and work.

This project is part of SRMC's increased emphasis on delivering care in the most appropriate outpatient setting possible, as close to the patient and community as possible. Innovations in care delivery and reimbursement continue to favor outpatient settings over traditional inpatient-based settings.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: Based on historical patient origin data, SRMC's service area for this Satellite ED project is one county – Sumner.

As reported in the hospital's FY2014 patient origin data, this one county area represented 76.0% of SRMC's total 36,733 inpatient discharges.

Similar patient origin referral patterns exist for emergency services as well, according to Tennessee Hospital Association patient origin data.

Exhibit 11
Sumner County Emergency Department Visits
Total and Sumner Regional Medical Center

	2012	2013	2014
All Sumner Co			
All ED Patients, All Hospitals[1]	69,768	69,824	78,507
Sumner Co Only at SRMC	32,286	32,763	31,360
SRMC Total (Tennessee)	36,645	37,296	36,189
Pct Sumner Co at SRMC	88.1%	87.8%	86.7%

Source: Tennessee Hospital Association patient origin data
[1]Total Sumner County resident ED visits at all Tennessee hospitals

Based on these historical patient origin data and refined further by area driving distances/times, the proposed service area is defined by a subset of zip codes. SRMC's service area for this Satellite ED project is comprised of two zip codes, both of which are located in Sumner County - 37066 and 37075. In 2014 and 2015, approximately 60% of SRMC's ED visits originated from this two zip code area.

Accounting for patient in-migration, approximately 5% of patients served are expected to reside outside the two zip codes identified.

Please see **Attachment C, Need – 3 (Tab 10)** for a county and zip code map related to the service area.

4. A. Describe the demographics of the population to be served by this proposal.

<u>**Response:**</u> SRMC's Satellite ED service area is comprised of two zip codes within Sumner County - 37066 and 37075.

Please see Exhibit 12, which illustrates the projected demographic changes in Sumner County and the State of Tennessee between 2015 and 2020.

EXHIBIT 12
SERVICE AREA DEMOGRAPHIC ANALYSIS

Demographic Data	Sumner County	State of TN Total
Total Population - 2015	175,054	6,649,438
Total Population - 2020	188,871	6,956,764
Total Population % Change	7.9%	4.6%
65+ Pop. - 2015	26,272	1,012,937
65+ Pop. - 2020	32,131	1,168,507
65+ Population % Change	22.3%	15.4%
65+ Population % of Total Population - 2015	15.0%	15.2%
Median Age[1]	39.3	38.6
Median Household Income[2]	$55,509	$44,298
TennCare Enrollees	28,161	1,422,145
TennCare Enrollees as % of Total Population	16.1%	21.4%
Persons Below Poverty Level	18,206	1,170,301
% of Total Population below Poverty Level[2]	10.4%	17.6%

[1]2014 data

[2]2009-2013 data

Source: Tennessee Department of Health (UT CBER Data), and US Census

Between 2015 and 2020, the population of Sumner County is projected to increase by 7.9%, or by 13,817 residents. This represents an annual growth rate of 1.5% and is greater than the projected growth rate of the state within that same five-year period, which is 0.9% annually, or 4.6% total growth.

The anticipated growth in the 65 and older population within the service area is much greater; nearly three times that of the total growth. Between 2015 and 2020, projections indicate that the senior population will increase 22.3%, or by 5,859 residents. For Tennessee, projections are that the total five-year growth within this age cohort will be 15.4%. Because seniors are among the highest users of healthcare services, such an explosive growth rate foretells the need for SRMC to anticipate increasing demand for services as result of this growth as well as that of the general population.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: SRMC has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2015, the 65 and older population will account for 15.0% of the total population in the service area. As a major demographic subgroup of SRMC's patient base, seniors will continue to expect the same level of service while becoming an increasingly larger segment of the total service area population, with 2020 projections placing the 65 and older population at 17.0% of the total service area population.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: Five hospitals treat 90.0% of the Sumner County ED visits according to Tennessee Hospital Association 2014 patient origin data.

Exhibit 13
Top Hospitals Serving Sumner County ED Patients

	2012		2013		2014	
Facility	Visits	%	Visits	%	Visits	%
Sumner Reg Med Cntr	32,286	46.3%	32,763	46.9%	31,360	39.9%
TriStar Hendersonville Med Cntr	22,095	31.7%	22,208	31.8%	22,765	29.0%
TriStar Portland Med Cntr		0.0%		0.0%	9,266	11.8%
Vanderbilt Univ Hosps	4,375	6.3%	4,257	6.1%	4,081	5.2%
TriStar Skyline Med Cntr	2,975	4.3%	2,827	4.0%	3,157	4.0%

Source: Tennessee Hospital Association Market IQ Data

According to 2013 JAR data, these same five hospitals treated almost 244,000 ED patients in 2013, or 17,728 more than in 2011. Since ED treatment rooms are not reported on the JAR, utilization by room cannot be calculated. However, average annual growth of 3.8% suggests strong demand for ED services.

Exhibit 14
ED Utilization Trends Among Top Hospitals

	2011	2012	2013	Annual Growth
Sumner Regional Medical Center	35,453	37,404	38,417	4.1%
Vanderbilt University Hospital	109,987	114,051	119,225	4.1%
TriStar Hendersonville Med Center	30,052	32,039	31,729	2.8%
TriStar Portland Med Center	-	-	-	-
TriStar Skyline Med Center	50,749	54,742	54,598	3.7%
Total	226,241	238,236	243,969	3.8%

Source: Joint Annual Reports for Hospitals

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE: As indicated below, SRMC serves approximately 38,000 emergency department patients annually with 26 treatment rooms. Planning guidelines from the American College of Emergency Physicians ("ACEP") recommend 1,500 patients per treatment room per year. At this level, SRMC operated at or above 100% capacity for the last three years.

Detailed projections for both the main hospital and Satellite ED were presented previously in the need section. As discussed previously, SRMC has based its need projections exclusively on the redirection of its own existing patients from the highly utilized SRMC main campus to the proposed Sumner Station satellite ED. Through this patient redirection, SRMC can achieve its projected patient volumes based on its own existing patients, with little or no adverse impact on existing providers.

Projected SRMC ED volumes are presented below.

Exhibit 15
SRMC ED Visit Projections

Sumner Station ED Visits		
	Year 1	**Year 2**
	7/2017 - 6/2018	**7/2018 - 6/2019**
Rooms	4	5
ED Visits	5,789	5,992
Visits/Room	1,447	1,198
Utilization @ 1,500	96.5%	79.9%
Utilization @ 1,800	80.4%	66.6%

SRMC Main Campus ED Visits (After Redirection)		
	Year 1	**Year 2**
	7/2017 - 6/2018	**7/2018 - 6/2019**
Rooms	26	26
ED Visits	35,453	36,694
Visits/Room	1,364	1,411
Utilization @ 1,500	90.9%	94.1%
Utilization @ 1,800	75.8%	78.4%

Total SRMC ED Visits, Main Campus and Sumner Station		
	Year 1	**Year 2**
	7/2017 - 6/2018	**7/2018 - 6/2019**
Rooms	30	31
ED Visits	41,242	42,686
Visits/Room	1,375	1,377
Utilization @ 1,500	91.6%	91.8%
Utilization @ 1,800	76.4%	76.5%

In conclusion, the Satellite ED can be expected to achieve 66.6% utilization by its second year of operation using 1,800 visits per room per year. The SRMC EDs combined will remain at approximately 76.5% utilization in years 1 and 2 of the project at 1,800 visits per room per year.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
   - The cost of any lease (building, land and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. NOTE: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
   - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

   RESPONSE: The CON filing fee is calculated at a rate of $2.25 per $1,000 of project costs as reported on Line D.

   Moveable equipment in Line A.8, over $50,000, include:

   - Portable Radiographic Equipment
   - Diagnostic Ultrasound
   - Chemistry Analyzer
   - Coagulation Analyzer
   - Central Monitor for the nursing station

   This project involves the renovation of existing shell space. Please see **Attachment C, Economic Feasibility – 1 (Tab 11)** for a letter supporting the construction costs.

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	$352,800
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$100,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs	$2,940,000
6.	Contingency Fund (Owner's Contingency)	$294,000
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment	$1,227,697
9.	Other	$676,200

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) ______________________	
5.	Other (Specify) ______________________	

C. Financing Costs and Fees:

1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	

D. Estimated Project Cost (A+B+C)	$5,590,697
E. CON Filing Fee	$12,579
F. Total Estimated Project Cost (D+E)	$5,603,276

TOTAL $5,603,276

2. Identify the funding sources for this project.
Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

___ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

___ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

___ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants--Notification of intent form for grant application or notice of grant award; or

_X_ E. Cash Reserves **(See Letter - Tab 12)**

___ F. Other—Identify and document funding from all other sources.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: At an average renovation cost of $288 per square foot, this project is comparable to other recently approved Tennessee CON projects. Exhibit 16, below, lists the average hospital renovation cost per square foot for all CON-approved applications for years 2012 through 2014.

EXHIBIT 16
HOSPITAL CONSTRUCTION COST PER SQUARE FOOT
APPROVED PROJECTS, 2012 - 2014

	Renovated Construction	New Construction	Total Construction
1st Quartile	$110.98/sq ft	$224.09/sq ft	$156.78/sq ft
Median	$192.46/sq ft	$259.66/sq ft	$227.88/sq ft
3rd Quartile	$297.82/sq ft	$296.52/sq ft	$298.66/sq ft

Source: Tennessee HSDA

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

   RESPONSE: Please refer to the completed charts on the four following pages. Historical data are provided for the entire hospital. Projected data are provided for the satellite ED only.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

   RESPONSE: Based on Year 2 projections, the average gross patient charge per emergency department visit is $2,727. The average deduction from gross patient charges, based on contractual allowances and allowances for charity care and bad debt, is approximately 75%, resulting in average net revenue per visit of approximately $684.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January.

		2012	2013	2014
A.	Utilization Data (Adjusted Admissions)	15,146	15,967	16,319
B.	Revenue from Services to Patients			
1.	Inpatient Services	$175,898,192	$216,941,678	$264,589,929
2.	Outpatient Services	171,489,000	188,307,150	157,201,017
3.	Emergency Services	78,129,348	102,802,172	136,365,556
4.	Other Operating Revenue (Specify) - Misc.	2,186,000	3,093,196	4,398,101
	Gross Operating Revenue	$427,702,540	$511,144,196	$562,554,603
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$288,553,000	$353,807,000	$409,226,538
2.	Provision for Charity Care	8,372,000	9,247,000	7,251,498
3.	Provisions for Bad Debt	18,874,000	24,814,000	22,524,972
	Total Deductions	$315,799,000	$387,868,000	$439,003,008
NET OPERATING REVENUE		$111,903,540	$123,276,196	$123,551,595
D.	Operating Expenses			
1.	Salaries and Wages	$50,953,000	$54,846,000	$57,493,341
2.	Physician's Salaries and Wages			
3.	Supplies	17,051,000	17,517,000	18,183,000
4.	Taxes	6,852,000	9,743,000	7,288,125
5.	Depreciation	9,691,000	8,501,000	8,547,000
6.	Rent	521,000	1,242,334	1,306,000

7. Interest, other than Capital			
8. Management Fees:			
a. Fees to Affiliates	4,089,000	4,408,000	4,892,000
b. Fees to Non-Affiliates			
9. Other Expenses (Specify)	18,608,000	19,353,000	23,660,011
Total Operating Expenses	$107,765,000	$115,610,334	$121,369,477
E. Other Revenue (Expenses) - Net (Specify)			
NET OPERATING INCOME (LOSS)	$4,138,540	$7,665,862	$2,182,118
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$4,138,540	$7,665,862	$2,182,118

Detail of Other Expenses			
Professional Fees	$2,628,000	$3,510,000	$5,483,120
Contract Services	$5,651,000	$5,791,000	$7,083,207
Repairs and Maintenance	$3,527,000	$3,890,000	$4,033,034
Utilities	$2,676,000	$2,743,000	$3,105,280
Insurance	$886,000	$692,000	$778,370
Other Operating Expenses (Marketing, recruiting etc)	$3,240,000	$2,727,000	$3,177,000
Total	$18,608,000	$19,353,000	$23,660,011

PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in January. (Numbers reported in thousands)

		Year 1 7/17-6/18	Year 2 7/18-6/19
A.	Utilization Data (Admissions)	5,789	5,992
B.	Revenue from Services to Patients		
1.	Inpatient Services		
2.	Outpatient Services		
3.	Emergency Services	$18,224	$19,144
4.	Other Operating Revenue (Specify)		
	Gross Operating Revenue	$18,224	$19,144
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$12,592	$13,252
2.	Provision for Charity Care		
3.	Provisions for Bad Debt	$2,187	$2,297
	Total Deductions	$14,779	$15,549
NET OPERATING REVENUE		$3,444	$3,595
D.	Operating Expenses		
1.	Salaries and Wages	$686	$704
2.	Physician's Salaries and Wages		
3.	Supplies	$365	$391
4.	Taxes	631	667
5.	Depreciation	$250	$250
6.	Rent		

7.	Interest, other than Capital		
8.	Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
9.	Other Expenses (See details below)	$524	$541
	Total Operating Expenses	$2,457	$2,552
E.	Other Revenue (Expenses) – Net (Specify)		
NET OPERATING INCOME (LOSS)		$988	$1,043
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest		
	Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$988	$1,043

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES		Year 1	Year 2
1.	E/R Physician Coverage Subsidy	$255	$263
2.	Information Systems Fees	$231	$238
3.	Repairs & Maintenance	$38	$40
4.			
5.			
6.			
7.			
	Total Other Expenses	**$524**	**$541**

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: SRMC presents the current and projected charges for an emergency department visit in Exhibit 17. An annual increase of 5% between 2014 and Year 1 of the project is projected. Afterwards, the hospital assumes that charges will increase by 1.5% annually. As demonstrated in Exhibit 18, SRMC's emergency department charges compare favorably with other providers in the service area.

EXHIBIT 17
SRMC EMERGENCY DEPARTMENT, HOSPITAL-BASED AND SATELLITE
AVERAGE GROSS CHARGE PER VISIT, CURRENT AND PROJECTED

	Current	Year 1	Year 2
Gross Charge	$2,998	$3,148	$3,195
Adjustment	$2,419	$2,553	$2,595
Net Revenue	$579	$595	$600

Source: Internal Data

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: Comparison charge data for emergency department visits is very limited. To compare its charges with similar facilities, SRMC relied upon Medicare data from the American Hospital Directory (AHD) or ahd.com, as a source. SRMC profiled the same five area hospitals serving Sumner County as presented above, from the AHD database.

Average charges per visit ranged from a low of $776 to a high of $1,443 with SRMC at $1,135. However, service mix indexes, a measure of patient severity, ranged from a low of 1.93 to a high of 4.64 with SRMC at 3.92. Adjusting the average charge by the service mix index resulted in a range of charges from a low of $290 to a high of $402 with SRMC as the lowest cost provider at $290. Please see **Exhibit 18**, which profiles the emergency department average charge data for the area hospitals.

Exhibit 18
Selected Hospitals Treating Sumner County Patients
2013 Average Gross Charge and Acuity Per Medicare Emergency Room Visit
Medicare claims data for calendar year ending 12/31/2013 (Final rule OPPS)

Service - Emergency Room	Patient Claims	Units of Service	Average Charge	Service Mix Index	Svc Mix Adjusted Avg Charge to 1.00
Sumner Regional Medical Center	4,035	4,047	$1,135	3.92	$289.54
Vanderbilt University Hospital	6,082	6,091	$1,443	4.64	$310.99
TriStar Hendersonville Med Center	5,404	5,822	$776	1.93	$402.07
TriStar Skyline Med Center	7,818	8,166	$839	2.25	$372.89
TriStar Portland Med Center*	-	-	-	-	-

*Began emergency services in 2014
Source: American Hospital Directory, ahd.com

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: SRMC is already financially feasible. Emergency services are an essential hospital responsibility to the community. This proposal will enhance SRMC's current service line by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Gallatin. Second, it will bring services closer to the communities where SRMC's patients now work and reside. This is vitally important for emergency services where ever minute counts. As indicated in the Projected Data Chart, projected utilization will be sufficient to continue to allow SRMC to operate efficiently and effectively. As this project is based strictly on the redirection of a portion of SRMC's existing ED patients from the main hospital campus to the satellite location, it will result in a corresponding "loss" of revenues at the main hospital ED in the initial years after the service is offered. However, this "loss" will be offset by the resulting patient revenues attained at the satellite location.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: As indicated in the Projected Data Chart, projected cash flow will ensure financial viability within two years and over the long-term.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: SRMC currently participates in both the Medicare and TennCare/Medicaid programs and has a history of providing care regardless of payor source. Using 2013 Joint Annual Report data, SRMC had an estimated payor mix (based on gross charges) that was 49.7% Medicare, 13.9% Medicaid/TennCare and 8.7% self pay. Additionally, based on the 2013 JAR, SRMC provided $9,236,720 in care to charity/medically indigent patients (accounting for 7.1% of net patient charges of $129,256,657). During the first year of operation, SRMC's satellite ED payor mix is anticipated to be 49.7% Medicare and 13.9% Medicaid/TennCare. This amounts to approximately $7,607,082 in Medicare gross charges in Year 1 and $2,127,534 Medicaid/TennCare gross charges in Year 1. In addition, SRMC proposes to provide $120,000 in charity care in Year 1.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

    RESPONSE: Please see **Attachment C, Economic Feasibility – 10 (Tabs 13 and 14)**.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

    a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

       RESPONSE: Although considered, renovating and enlarging the existing emergency department at Sumner Regional Medical Center is not a viable option. The emergency department at SRMC is located in a basement area, and due to the facility layout, is unable to expand. The three treatment rooms added in 2014 represent the area's maximum capacity. To attempt to expand further would be cost prohibitive. As SRMC's campus has become increasingly crowded, the hospital has been actively pursuing a strategy of moving outpatient services into other areas of the surrounding communities, specifically at Sumner Station. This is evidenced generally by the development of outpatient diagnostic services and cancer services.

       Emergency services are an essential hospital responsibility to the community. This proposal will enhance SRMC's current service line by expanding emergency department capacity off the main hospital campus. This will accomplish two important goals. First, it will decompress services already limited by space constraints in downtown Gallatin. Second, it will bring services closer to the communities where SRMC's patients now work and reside. This is vitally important for emergency services where every minute counts.

       With regard to this particular project, SRMC already owns the shelled space for the proposed emergency department, its Sumner Station outpatient facility. This will allow the project to be completed exclusively in renovated space, a much more cost efficient option than new construction. Additionally, Sumner Station already operates a full service imaging center that will be utilized by the proposed emergency department, saving millions of dollars in duplicate equipment and construction costs.

       Thus, this project addresses the site deficiency at SRMC's existing in-town campus and does so in a cost-effective approach by leveraging existing imaging services in Gallatin.

    b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

RESPONSE: As discussed above, further modernization/expansion of the existing emergency department in downtown Gallatin was not a viable alternative. With the existing emergency department suffering from space constraints and seeing increasing utilization, SRMC has been actively pursuing a strategy of moving key outpatient services into its Sumner Station outpatient facility.

As discussed, SRMC already owns the shelled space for the proposed emergency department, its Sumner Station outpatient facility. This will allow the project to be completed exclusively in renovated space, a much more cost efficient option than new construction. Additionally, Sumner Station already operates a full service imaging center that will be utilized by the proposed emergency department, saving millions of dollars in duplicate equipment and construction costs.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

   RESPONSE: Lists of managed care contracts and provider contracts are attached under Attachment C, Contribution to the Orderly Development of Health Care - 1.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   RESPONSE: SRMC's proposal will have a positive impact on the health care system, through improved patient convenience. As documented previously, population growth alone from 2015 to 2020 is expected to generate demand for an additional five to seven emergency treatment rooms in Sumner County, four to six of which are required in the proposed two zip code satellite ED service area. These are incremental emergency treatment rooms, and thus would have no effect on the utilization rates of existing providers in the service area.

   That said, SRMC's satellite ED need methodology assumptions propose strictly to redirect its own existing patients from the SRMC main campus to the proposed Sumner Station satellite ED facility, with absolutely no impact on outside providers.

   Service area residents will experience a positive impact by having increased access to SRMC's emergency services closer to their communities, where they work and live. This is vitally important for emergency services where ever minute counts.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

   RESPONSE: Exhibit 19 illustrates current and proposed staffing levels for the proposed project. SRMC proposes adding 41.9 FTEs.

EXHIBIT 19
CURRENT AND PROPOSED STAFFING LEVELS
SATELLITE ED AT SUMNER STATION
(FULL TIME EQUIVALENTS)

Position	Current	Proposed	Difference
Lab	0.0	5.2	5.2
Nursing and Respiratory Therapy	0.0	24.1	24.1
Imaging	0.0	4.2	4.2
Registration	0.0	4.2	4.2
Physician	0.0	4.2	4.2
TOTAL	**0.0**	**41.9**	**41.9**

SRMC has a history of successfully retaining professional and administrative staff because it provides competitive benefits and compensation, and provides a supportive work environment.

Exhibit 20 profiles comparable positions and salaries for the Nashville-Davidson-Murfreesboro MSA. SRMC's salaries and wages, before benefits, are competitive with the market. The proposed project's average proposed annual salary for registered nurses is $59,488. These values are within the ranges for the Nashville-Davidson-Murfreesboro MSA.

EXHIBIT 20
NASHVILLE-DAVIDSON-MURFREESBORO MSA
MAY 2014 ANNUAL WAGE RATES

Position	25th Pctile	Mean	Median	75th Pctile
Registered Nurse	$49,340	$59,310	$58,870	$69,550

SOURCE: ANNUAL SALARY BLS OCCUPATIONAL EMPLOYMENT STATISTICS SURVEY DATA

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

   RESPONSE: SRMC proposes adding 41.9 FTEs. SRMC has a history of successfully recruiting professional and administrative staff. It provides competitive benefits and compensation, and is committed to the retention of existing personnel. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 4 (Tab 16)** for the CVs of physicians that will participate at the Satellite ED.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

   RESPONSE: SRMC has reviewed and understands the licensure and certification requirements for medical and clinical staff. The Satellite ED will rely on the experience and expertise of the emergency department physicians now at SRMC. The proposed full service, 24-hour-per-day/7-day-per-week satellite emergency department facility will be a satellite of the main emergency department at SRMC and will be under the sole administrative control of SRMC. As an existing licensed and Joint Commission-accredited facility, SRMC has administrative policies and procedures in place to ensure that licensure and certification requirements are followed. Furthermore, SRMC maintains quality standards that are focused on continual improvement. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 5** for copies of its Continuous Quality Improvement Plan **(Tab 17)**, and Utilization Review Plan **(Tab 18)** and Patient Rights and Responsibilities **(Tab 19)**.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

<u>**RESPONSE:**</u> SRMC participates in many regional healthcare teaching and training programs. Each of these clinical rotations provides the student with hands-on training in their particular area of study. Students are assigned to preceptors from within each department of study to provide supervision and to act as the instructor in their field of expertise. The following clinical affiliations are in place for SRMC:

<u>ER Medical Resident and Medical Student Program</u> – SRMC currently has 12 medical residents in the class this year, increasing to 13 students next year. Each second year resident and each third year Emergency Medicine resident rotates to SRMC for a two week rotation each year (the equivalent of 1 FTE resident per month for all 12 months is provided). Additionally, SRMC also rotates through approximately 100 medical students yearly for 2-3 shifts each month. These medical students complete an observational day in ED and are assigned to the SRMC Emergency Physicians.

<u>Medical Imaging</u> – Students are assigned within the varied sections of medical imaging; x-ray, ultrasound, CT, MRI etc.

<u>Respiratory Therapy</u> – Students are assigned to routine care, critical care, emergency department and code team.

<u>Nursing</u> – Student from multiple schools are assigned to the Emergency Department (as well as other units) to gain advanced critical care knowledge. These students are precepted by nurses from the critical care areas.

<u>Pharmacy</u> – Students from multiple schools and at different levels within their pharmacy education participate in all facets of the pharmacy.

<u>EMT/AEMT/Paramedics</u> – Students from all three levels of emergency response students are assigned to the Emergency department. Their participation ranges from observation to hands on procedures depending upon their level of training.

<u>Nurse Anesthetists</u> – Nurse anesthetist students are assigned to the SRMC anesthesiologists for hands on training.

There are additional, less frequent students from other ancillary departments such as, Rehab, Nutrition, HIM, Informatics, Sleep study and Administration.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: As an existing hospital, SRMC is licensed by the Tennessee Department of Health. SRMC has reviewed and understands the licensure requirements. The proposed full service, 24-hour-per-day/7-day-per-week satellite emergency department facility will be a satellite of the main emergency department at SRMC and will be under the sole administrative control of SRMC.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Board of Licensing Health Care Facilities, State of Tennessee, Department of Health.

Accreditation: SRMC is accredited by The Joint Commission (on Accreditation of Healthcare Organizations). Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(b) (Tab 20)** for the most recent report.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(c) (Tab 21).** The current license is valid until June 25, 2016.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(d)** for a copy of the most recent licensure/certification inspection report **(Tab 22)** and plan of corrective action **(Tab 23)**.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

   Response: There have been no final orders or judgments placed against SRMC or any entity or person with more than 5 percent ownership.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

   Response: There have been no civil or criminal judgments against SRMC or any entity or person with more than 5 percent ownership.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required.

    Response: Yes, SRMC will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required. Additionally, SRMC submits a Joint Annual Report (JAR) to the Department of Health and will continue to do so.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Please see **Attachment D – Proof of Publication (Tabs 24-25).**

DEVELOPMENT SCHEDULE

Tennessee Code Annotated §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   RESPONSE: The project completion schedule below reflects the anticipated schedule for the construction project.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT FORECAST COMPLETION CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): November 2015

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	30	Dec-15
2. Construction documents approved by the Tennessee Department of Health	180	May-16
3. Construction contract signed	240	Jul-16
4. Building permit secured	270	Aug-16
5. Site preparation completed	N/A	N/A
6. Building construction commenced	270	Aug-16
7. Construction 40% complete	360	Nov-16
8. Construction 80% complete	420	Jan-17
9. Construction 100% complete (approved for occupancy)	480	Mar-17
10. *Issuance of license	570	Jun-17
11. *Initiation of service	580	Jul-17
12. Final Architectural Certification of Payment	580	Jul-17
13. Final Project Report Form (HF0055)	640	Sep-17

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Sumner

Michael Herman being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 10th day of August (Month) 2015 (Year) a Notary Public in and for the County/State of Sumner County, Tennessee

NOTARY PUBLIC

My commission expires October 28 (Month/Day), 2018 (Year).

LISA R. WEBB
STATE OF TENNESSEE NOTARY PUBLIC
SUMNER COUNTY
My Commission Expires October 28, 2018

THIS DOCUMENT HAS A VOID BACKGROUND · MICROPRINT BORDERS AND SIGNATURE LINE · WATERMARK ON BACK. HOLD UP TO LIGHT TO VIEW

Cashier's Check

66-30/531

Branch No. 913

FirstCitizensBank
First-Citizens Bank & Trust Company
Raleigh, North Carolina

09001316

Date August 12, 2015

Pay to the order of ****TN HEALTH SERVICES AND DEVELOPMENT AGENCY**** $ $12,579.07

FIRST CITIZENS BANK BRANCH 913 12579 DOLS 07 CTS Dollars

Notice To Customers
The purchase of an Indemnity Bond or an Insurance Bond may be required before an official check of this bank will be replaced or refunded in the event it is lost, misplaced or stolen.

Remitter ****THE STRATEGY HOUSE, INC.****

05-10050R (02/14)

04FCM0115

⑈09001316⑈ ⑆053100300⑆9801994990⑈

Cashier's Check

66-30/531

Branch No. 913

FirstCitizensBank
First-Citizens Bank & Trust Company
Raleigh, North Carolina

09001316

Date August 12, 2015

Pay to the order of ****TN HEALTH SERVICES AND DEVELOPMENT AGENCY**** $ $12,579.07

Twelve Thousand Five Hundred Seventy Nine Dollars and 07/100 Dollars

Notice To Customers
The purchase of an Indemnity Bond or an Insurance Bond may be required before an official check of this bank will be replaced or refunded in the event it is lost, misplaced or stolen.

Remitter ****THE STRATEGY HOUSE, INC.****

CUSTOMER COPY
NON-NEGOTIABLE

05-10050R (02/14)

03131

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Organizational Chart
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Tab 1

Attachment A, 3

Certificate of Formation

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "SUMNER REGIONAL MEDICAL CENTER, LLC", FILED IN THIS OFFICE ON THE NINETEENTH DAY OF MAY, A.D. 2010, AT 4:11 O'CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

4825590 8100

AUTHENTICATION: 8005193

100536424

DATE: 05-20-10

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 04:25 PM 05/19/2010
FILED 04:11 PM 05/19/2010
SRV 100536424 - 4825590 FILE

Certificate of Formation
of
Sumner Regional Medical Center, LLC

The undersigned, an authorized natural person, for the purpose of forming a limited liability company, under the provisions and subject to the requirements of the State of Delaware, particularly Chapter 18, Title 6 of the Delaware Code and the acts amendatory thereof and supplemental thereto, and known, identified, and referred to as the Delaware Limited Liability Company Act (the "Act"), hereby certifies that:

FIRST: The name of the limited liability company is Sumner Regional Medical Center, LLC (the "Company").

SECOND: The address of the registered office and the name and address of the registered agent of the Company required to be maintained by Section 18-104 of the Act is The Corporation Trust Company, Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

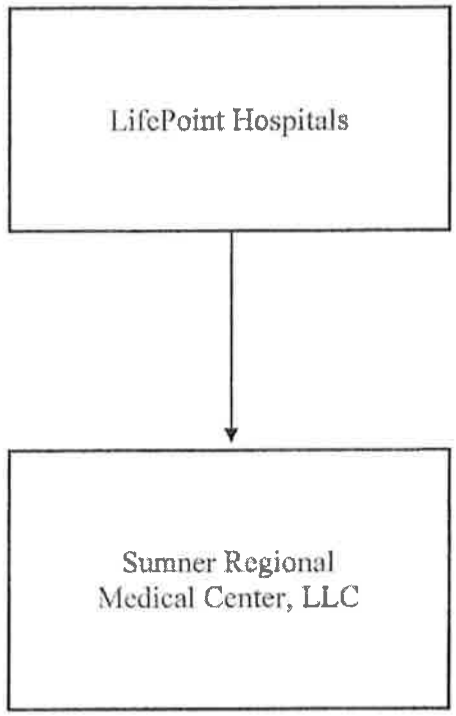
IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation as of May 19, 2010.

By: MKShipp
Mary Kim E. Shipp
Authorized Person

Tab 2

Attachment A, 4

Organizational Chart



Note: This chart shows only the entities pertinent to the application. It is not possible to produce a chart that includes all 58 hospitals operated by LifePoint, but a list of LifePoint hospitals in Tennessee is attached.

LifePoint Hospitals in Tennessee

Livingston Regional Hospital
315 Oak Street
Livingston, TN 38570

Riverview Regional Medical Center
158 Hospital Dr
Carthage, TN 37030

Southern Tennessee Regional Healthy System at Lawrenceburg
1607 South Locust Ave
Lawrenceburg, TN 38464

Southern Tennessee Regional Health System at Sewanee
1260 University Ave
Sewanee, TN 37375

Southern Tennessee Regional Health System at Pulaski
1265 East College Street
Pulaski, TN 38478

Southern Tennessee Regional Health System at Winchester
185 Hospital Rd
Winchester, TN 37398

Starr Regional Medical Center
1114 West Madison Ave
Athens, TN 37303

Starr Regional Medical
886 Highway 411 North
Etowah, TN 37331

Sumner Regional Medical Center
555 Hartsville Pike
Gallatin, TN 37066

Trousdale Medical Center
500 Church Street
Hartsville, TN 37074

Tab 3

Attachment A, 4

Senior Leadership

Quick Links

About Us
Contact Us
Community Benefit Report
HighPoint Health System
Senior Leadership
Mission, Vision & Values

Senior Leadership

Susan Peach, BSN, MBA
Chief Executive Officer

Susan Peach, BSN, MBA, became the new chief executive officer of HighPoint Health System in July 2012. A veteran hospital administrator with more than 30 years of healthcare experience, Susan came to HighPoint Health System from LifePoint Hospitals' Hospital Support Center, where she served as chief nursing officer of the Delta Division since 2010. In that role, she provided clinical leadership and oversight for nine LifePoint Hospitals, including the four hospital campuses of HighPoint Health System.

Prior to joining LifePoint, Susan served as senior vice president, Performance Management, for Catholic Health Initiatives from 2003 to 2010; vice president, Strategic Quality Management and Clinical Services, and system chief nursing officer for Quorum Health Resources from 1996 to 2003; and chief executive officer (1995-1996) and chief operating officer (1992-1995) at Rockdale Regional Medical Center.

Peach holds a Master of Business Administration degree from Georgia State University and a Bachelor of Science degree in nursing from Clayton College. She is also a Six Sigma Black Belt. Peach and her husband Jim are residents of Sumner County.

Bob Barrett, CPA
Market Chief Financial Officer

Bob Barrett, CPA, became the new Market Chief Financial Officer for HighPoint Health System in July 2014. Bob began his career with LifePoint Hospitals® as a member of their Audit Services team at the LifePoint Hospital Support Center in 2004. He then participated in LifePoint's "Officer Development Program" and has served in a number of CFO roles since 2008. He has also worked closely with LifePoint Group financial leadership on several projects and comes to HighPoint with a solid reputation as a critical thinker and great leader.

Barrett came to HighPoint most recently from Georgetown Community Hospital, a 75-bed acute care hospital in Lexington, Ky., which includes eight employed physician practices and a regional Centralized Billing Office serving 82 physicians across the state, where he has been CFO since April 2012. From 2010 to 2012, he was the CFO at Clinch Valley Medical Center, a 175-bed acute care hospital in Richlands, Va. Prior to that, he was CFO at Logan Memorial Hospital, a 92-bed acute care hospital in Russellville, Ky.

He earned a Bachelor of Science degree in Accounting from Lipscomb University in Nashville, Tenn., and a Master of Accountancy degree from Belmont University, also in Nashville, Tenn. He is a Certified Public Accountant.

Michael S. Herman
Chief Operating Officer

Mike Herman came to HighPoint Health System as Chief Operating Officer in 2011 from Trident Health System in Charleston, SC. He spent three years at Trident as Vice President of Operations at the system's 94-bed Summerville Medical Center in Summerville, and brought more than a decade of senior-level operations experience to HighPoint. Prior to that, he worked for three years as the Senior Operations Analyst at the 242-bed Doctors Hospital of Augusta, Ga., and spent four years at the 278-bed North Florida Regional Medical Center in Gainesville, Fla., where he started as the Operating Department Administrative Assistant and Sterile Processing Tech, before being promoted to Operations Analyst for the hospital.

Herman earned both a bachelor's degree in Food Science and Human Nutrition and a master's degree in Health Administration at the University of Florida, Gainesville. He is a Fellow of the American College of Healthcare Executives, and a member of the Gallatin Morning Rotary Club. Herman is also a graduate of Leadership Augusta.

Anne Melton, RN, MSN
Chief Nursing Officer

Anne Melton joined Sumner Regional Medical Center (SRMC) in 2006 as Director of Nursing, and is currently vice president of clinical services. Her 30-year nursing career includes former leadership roles such as director of medical and surgical nursing at Middle Tennessee Medical Center (Murfreesboro, TN) and management at Vanderbilt University Medical Center (Nashville, TN). At SRMC, Melton has served on various clinical safety committees, and most recently she assisted with the transition of patients to SRMC's new patient tower and with clinical preparation for recent Women's Center renovations. Melton has also been instrumental in strategic planning for the growth and development of SRMC's Women's Services. She provides oversight for nursing services, emergency services, inpatient

000061

Tab 4

Attachment A, 4

Certificate of Corporate Existence

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

KEVIN KIMBELL
71 VICKERY STREET
ROSWELL, GA 30075

July 23, 2015

Request Type: Certificate of Existence/Authorization
Request #: 0169979

Issuance Date: 07/23/2015
Copies Requested: 1

Document Receipt

Receipt # : 002160533 Filing Fee: $22.25

Payment-Credit Card - State Payment Center - CC #: 163824999 $22.25

Regarding: Sumner Regional Medical Center, LLC
Filing Type: Limited Liability Company - Foreign
Formation/Qualification Date: 05/25/2010
Status: Active
Duration Term: Perpetual

Control # : 632152
Date Formed: 05/19/2010
Formation Locale: DELAWARE
Inactive Date:

CERTIFICATE OF AUTHORIZATION

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

Sumner Regional Medical Center, LLC

* is a Limited Liability Company formed in the jurisdiction set forth above and is authorized to transact business in this State;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed an Application for Certificate of Withdrawal.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 012904829

Tab 5

Attachment A, 6

Deed

RECORDED ELECTRONICALLY
ID 1071080 County Sumner
Date 12-3-13 Time 3:11 Pm
simplifile www.simplifile.com 800.460.5657

1

FROM: Citadel Properties V, L.L.C.

TO: Sumner Regional Medical Center, LLC

Address New Owner as Follows:	Send Tax Bills To:	Map-Parcel No.
Sumner Regional Medical Center, LLC, a Delaware limited liability company c/o Lifepoint Hospitals 103 Powell Court Brentwood, TN 37027	SAME	Map 137, Parcels 8.01, 8.02, 8.03 and 8.04

THIS INSTRUMENT PREPARED BY: Waller Lansden Dortch & Davis, LLP, 511 Union Street, Suite 2700, Nashville, Tennessee 37219-1760

STATE OF Tennessee)
COUNTY OF Williamson)

The actual consideration or value, whichever is greater, for this transfer is $18,000,000.00.

Affiant

Subscribed and sworn to before me, this the 22 day of November, 2013.

Gretchen E. Catron
Notary Public

Gretchen E. Catron State of Tennessee Notary Public Williamson County My Commission Expires September 26, 2016

My Comm. Expires: 9-26-2016

SPECIAL WARRANTY DEED

KNOW ALL MEN BY THESE PRESENTS, that for and in consideration of the sum of TEN DOLLARS ($10.00) cash in hand paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, CITADEL PROPERTIES V, L.L.C., an Illinois limited liability company ("Grantor"), has bargained and sold, and by these presents does transfer and convey unto SUMNER REGIONAL MEDICAL CENTER, LLC a Delaware limited liability company ("Grantee"), the successors and assigns of Grantee, that certain tract or parcel of land in Sumner County, Tennessee, described on Exhibit A attached hereto and incorporated herein (the "Property"), subject to, however, those exceptions and encumbrances set forth on Exhibit B attached hereto and incorporated herein.

This is improved property known as 225 Big Station Camp Boulevard, Gallatin, Tennessee 37066.

TO HAVE AND TO HOLD the Property together with all appurtenances and hereditaments thereunto belonging or in any wise appertaining to Grantee, the heirs, representatives, successors and assigns of Grantee, forever.

Grantor further covenants and binds itself, its representatives, successors and assigns to warrant and forever defend the title to the Property to Grantee, the heirs, representatives, successors and assigns of Grantee, against the lawful claims of all persons whomsoever claiming by, through or under Grantor but excluding the claims of persons claiming by, through or under any current tenant of Grantor under the leases and set forth on Exhibit B, but not further or otherwise subject to the matters set forth on Exhibit B.

Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

IN WITNESS WHEREOF, this instrument has been executed this 27th day of November, 2013.

CITADEL PROPERTIES ~~V, L.L.C.~~, a Illinois limited liability company

By: [signature]
Name: David L. Varwig
Title: Sole Manager

STATE OF Illinois)
COUNTY OF Lake)

Before me, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared David Varwig, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the Sole Manager of Citadel Properties V, L.L.C., the within named bargainor, a limited liability company, and that (s)he executed the foregoing instrument for the purposes therein contained, by signing the name of the limited liability company by himself/herself as Sole Manager.

Witness my hand, at office, this 27th day of November, 2013.

Carolyn L. Jelks
Notary Public

My Commission Expires: 3-11-14

OFFICIAL SEAL
CAROLYN L. JELKS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES MAR 11, 2014

EXHIBIT A

Legal Description

LAND IN THE FOURTH CIVIL DISTRICT OF SUMNER COUNTY, TENNESSEE. BEING THE PROPERTY OF SUMNER REGIONAL HEALTH SYSTEMS, INC., AS OF RECORD IN BOOK 2635, PAGE 828, REGISTER'S OFFICE SUMNER COUNTY, TENNESSEE AND RECORD BOOK 2718, PAGE 773, REGISTER'S OFFICE SUMNER COUNTY, TENNESSEE. DESCRIBED MORE PRECISELY AS FOLLOWS:

BEGINNING AT A POINT AT A HIGHWAY MONUMENT ON THE NORTHERN RIGHT-OF-WAY OF LOWER STATION CAMP CREEK ROAD, SAID POINT BEING LOCATED ON THE WESTERN RIGHT-OF-WAY OF STATE ROUTE 386 AND BEING THE SOUTHEAST CORNER OF THIS PARCEL;

THENCE WITH THE NORTHERN RIGHT-OF-WAY OF LOWER STATION CAMP CREEK ROAD AND A CURVE TO THE LEFT, DELTA OF 14'31'46", RADIUS OF 625.00 FEET, LENGTH OF 158.49 FEET AND A CHORD BEARING OF N 75'06'13" W 158.07 FEET TO AN IRON ROD ON THE NORTHERN RIGHT-OF-WAY OF SAID ROAD;

THENCE LEAVING SAID ROAD, N 08'59'01" E 2000.68 FEET TO AN IRON ROD ON THE SOUTHERN MARGIN OF NEW STATION CAMP CREEK ROAD;

THENCE, S 42'54'44" E 718.20 FEET TO AN IRON ROD ON THE SOUTHERN RIGHT OF-WAY OF NEW STATION CAMP CREEK ROAD;

THENCE, S 47'03'45" W 24.95 FEET TO A POINT AT A HIGHWAY MONUMENT AND THE RIGHT-OF-WAY OF STATE ROUTE 386;

THENCE WITH THE RIGHT-OF-WAY OF STATE ROUTE 386 FOR THE NEXT EIGHT CALLS;

S 34'24'24" E 101.12 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 41'55'01" E 168.45 FEET TO A POINT AT A HIGHWAY MONUMENT;

CHORD BEARING OF S 09'38'23" E 203.13 FEET, RADIUS OF 185.00 FEET AND A LENGTH OF 215.03 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 23'39'29" W 292.22 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 26'23'25" W 228.79 FEET TO A POINT AT A HIGHWAY MONUMENT;

CHORD BEARING OF S 35'21'34" W 85.59 FEET, RADIUS OF 743.51 FEET AND A LENGTH OF 85.63 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 45'49'36" W 228.57 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 47'53'25" W 541.42 FEET TO THE POINT OF BEGINNING;

CONTAINING 24.58 ACRES, MORE OR LESS.

Being the same property conveyed to Citadel Properties V, L.L.C., an Illinois limited liability company, by deed from SRHS Bankruptcy, Inc., of record in Record Book 3731, page 187, Register's Office for Sumner County, Tennessee.

EXHIBIT B

Permitted Exceptions

1. Taxes for 2013 and subsequent years.

2. Declaration of Easement and Maintenance Agreement of record in Record Book 2733, page 441, said Register's Office.

3. Water/sewer easement of record in Record Book 1343, page 417, said Register's Office.

4. Public Utility easement of record in Record Book 1481, page 228, said Register's Office.

5. Grant of Transmission Line Easement of record in Deed Book 174, page 370, said Register's Office.

6. Lease (Outpatient Diagnostic Center) dated April 1, 2007, between Citadel Properties V, L.L.C. and Sumner Regional Health Systems, Inc., successor in interest to Sumner Regional Medical Center, Inc., for approximately 11,757 square feet of diagnostic center space.

7. Lease (Clinic Space) dated April 1, 2007, between Citadel Properties V, L.L.C. and Sumner Regional Health Systems, Inc., successor in interest to Sumner Regional Medical Center, LLC for approximately 8,304 square feet of clinic space.

8. Matters shown on survey prepared by L. Steven Bridges, Jr., as Job N. 3218, dated September 27, 2013, last revised November 5, 2013.

9. Laws and ordinances affecting the Property.

Pamela L. Whitaker, Register
Sumner County Tennessee

Rec #: 822259		Instrument #: 1071080
Rec'd:	25.00	Recorded
State:	66600.00	12/3/2013 at 3:11 PM
Clerk:	1.00	in Record Book
Other:	2.00	3877
Total:	66628.00	Pages 594-598

FORWARDED TO SUMNER COUNTY ASSESSOR OF PROPERTY ON DATE OF RECORDING

FROM: Citadel Properties V, L.L.C.

TO: Sumner Regional Medical Center, LLC

Address New Owner as Follows:	Send Tax Bills To:	Map-Parcel No.
Sumner Regional Medical Center, LLC, a Delaware limited liability company c/o Lifepoint Hospitals 103 Powell Court Brentwood, TN 37027	SAME	Map 137, Parcels 8.01, 8.02, 8.03 and 8.04

THIS INSTRUMENT PREPARED BY: Waller Lansden Dortch & Davis, LLP, 511 Union Street, Suite 2700, Nashville, Tennessee 37219-1760

STATE OF Tennessee)
COUNTY OF Williamson)

The actual consideration or value, whichever is greater, for this transfer is $18,000,000.00.

____
Affiant

Subscribed and sworn to before me, this the 22 day of November, 2013.

____
Notary Public

Gretchen D. Catron
State of Tennessee Notary Public
Williamson County
My Commission Expires September 26, 2016

My Comm. Expires: 9-26-2016

SPECIAL WARRANTY DEED

KNOW ALL MEN BY THESE PRESENTS, that for and in consideration of the sum of TEN DOLLARS ($10.00) cash in hand paid, and other good and valuable consideration, the receipt of which is hereby acknowledged, CITADEL PROPERTIES V, L.L.C., an Illinois limited liability company ("Grantor"), has bargained and sold, and by these presents does transfer and convey unto SUMNER REGIONAL MEDICAL CENTER, LLC a Delaware limited liability company ("Grantee"), the successors and assigns of Grantee, that certain tract or parcel of land in Sumner County, Tennessee, described on Exhibit A attached hereto and incorporated herein (the "Property"), subject to, however, those exceptions and encumbrances set forth on Exhibit B attached hereto and incorporated herein.

This is improved property known as 225 Big Station Camp Boulevard, Gallatin, Tennessee 37066.

TO HAVE AND TO HOLD the Property together with all appurtenances and hereditaments thereunto belonging or in any wise appertaining to Grantee, the heirs, representatives, successors and assigns of Grantee, forever.

Grantor further covenants and binds itself, its representatives, successors and assigns to warrant and forever defend the title to the Property to Grantee, the heirs, representatives, successors and assigns of Grantee, against the lawful claims of all persons whomsoever claiming by, through or under Grantor but excluding the claims of persons claiming by, through or under any current tenant of Grantor under the leases and set forth on Exhibit B, but not further or otherwise subject to the matters set forth on Exhibit B.

Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

IN WITNESS WHEREOF, this instrument has been executed this 27th day of November, 2013.

CITADEL PROPERTIES ~~V, L.L.C.~~, a Illinois limited liability company

By: ____________________
Name: David L. Varwig
Title: Sole Manager

STATE OF Illinois)
COUNTY OF Lake)

Before me, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared David Varwig, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the Sole Manager of Citadel Properties V, L.L.C., the within named bargainor, a limited liability company, and that (s)he executed the foregoing instrument for the purposes therein contained, by signing the name of the limited liability company by himself/herself as Sole Manager.

Witness my hand, at office, this 27th day of November, 2013.

Carolyn L Jelks
Notary Public

My Commission Expires: 3-11-14

OFFICIAL SEAL
CAROLYN L JELKS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES MAR 11, 2014

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S 41°55'01" E 168.45 FEET TO A POINT AT A HIGHWAY MONUMENT;

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S 23°39'29" W 292.22 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 26°23'25" W 228.79 FEET TO A POINT AT A HIGHWAY MONUMENT;

CHORD BEARING OF S 35°21'34" W 85.59 FEET, RADIUS OF 743.51 FEET AND A LENGTH OF 85.63 FEET TO A POINT AT A HIGHWAY MONUMENT;

S 45°49'36" W 228.57 FEET TO A POINT AT A HIGHWAY MONUMENT;

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Being the same property conveyed to Citadel Properties V, L.L.C., an Illinois limited liability company, by deed from SRHS Bankruptcy, Inc., of record in Record Book 3731, page 187, Register's Office for Sumner County, Tennessee.

EXHIBIT B

Permitted Exceptions

1. Taxes for 2013 and subsequent years.

2. Declaration of Easement and Maintenance Agreement of record in Record Book 2733, page 441, said Register's Office.

3. Water/sewer easement of record in Record Book 1343, page 417, said Register's Office.

4. Public Utility easement of record in Record Book 1481, page 228, said Register's Office.

5. Grant of Transmission Line Easement of record in Deed Book 174, page 370, said Register's Office.

6. Lease (Outpatient Diagnostic Center) dated April 1, 2007, between Citadel Properties V, L.L.C. and Sumner Regional Health Systems, Inc., successor in interest to Sumner Regional Medical Center, Inc., for approximately 11,757 square feet of diagnostic center space.

7. Lease (Clinic Space) dated April 1, 2007, between Citadel Properties V, L.L.C. and Sumner Regional Health Systems, Inc., successor in interest to Sumner Regional Medical Center, LLC for approximately 8,304 square feet of clinic space.

8. Matters shown on survey prepared by L. Steven Bridges, Jr., as Job N. 3218, dated September 27, 2013, last revised November 5, 2013.

9. Laws and ordinances affecting the Property.

True Copy Certification

I, Mark Lee, do hereby make oath that I am a licensed attorney and/or the custodian of the electronic version of the attached document tendered for registration therewith and that this is a true and correct copy of the original documents executed and authenticated according to law.

Mark Lee
Signature

State of Tennessee

County of Shelby

Personally appeared before me, Michele M. Clark, a notary public for this county and state, Mark Lee, who acknowledges that this certification of an electronic document is true and correct and whose signature I have witnessed.

Michele M. Clark
Notary's Signature

My Commission Expires: 7-16-2017

Notary Seal:

MICHELE M. CLARK
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

Tab 6

Attachment A, 13

MCO/BHO Participation, Transfer Agreements

HighPoint Health System Affiliates
Insurance Contract Name and Network Plan Types
Last Updated 1-2014

		Sumner Regional Medical Center		Trousdale Medical Center	Riverview Regional Medical Center	Sumner Homecare and Hospice			
		Hospital	Sumner Inpatient Rehab Unit	Hospital	Hospital	Carthage	Gallatin	Goodlettsville	Hospice
AmeriChoice - (United Healthcare Community Plan as of 01/01/11)	TennCare MCO	●		◆ No Swing	✖ No Swing	■	■	■	■
AmeriGroup - Community Care	TennCare HMO	●		◆ No Swing	✖ No Swing	■	■	■	■
Aetna	HMO, POS, PPO	●	●	◆	✖	■	■	■	■
BeechStreet	PPO Network	●	●	◆	✖	■	■	■	■
Blue Network P (Blue Preferred)	PPO	●	●	◆ No Swing	✖ No Swing	■	■	■	■
Blue Network S (Blue Select)	PPO/POS	●	●	◆ No Swing	✖ No Swing	■	■	■	■
Blue Network V (CoverTN)	HMO Limited Benefit Policy	● No Wound Care	●	◆ No Swing	✖ No Swing	■	■	■	■
BlueCare / TennCare Select	TN Medicaid Program	●		◆ No Swing	✖ No Swing	■	■	■	■
Center Care PPO	PPO Network	●	●	◆	✖	■	■	■	■
Cigna	HMO, POS, PPO	●	●	◆	✖	■	■		■
Corvel Work Comp	PPO	●	●	◆	✖	■	■	■	■
First Health (Includes CCN PPO)	PPO Network	●	●	◆	✖	■	■	■	■
Great West Healthcare	HMO, POS, PPO	●	●	◆	✖	■	■	■	■
HealthScope Benefits (Access the CenterCare Network in TN)	PPO Network	●	●	◆	✖	■	■	■	■
HealthSpring Commercial Plans	HMO, POS	●	●	◆	✖	■	■	■	■
HealthSpring Medicare Advantage Plans	Medicare HMO and PPO	●	●	◆	✖	■	■	■	■
Humana ChoiceCare Network	POS, PPO	●	●	◆	✖	■	■	■	■
Humana Medicare PPO	Medicare PPO	●	●	◆	✖	■	■	■	■
MultiPlan	PPO Network	●	●	◆	✖	■	■	■	■
NovaNet	PPO Network	●	●	◆	✖	■	■	■	■
PPO USA (GEHA)	PPO Network	●	●	◆	✖	■	■	■	■
ppoNext	PPO Network	●	●	◆	✖	■	■	■	■
Prime Health Services	PPO Network	●	●	◆	✖	■	■	■	■
Private Health Care Systems (PHCS)	PPO Network	●	●	◆	✖	■	■	■	
Principal Edge Network	PPO Network	●	●	◆	✖	■	■	■	
Provider Networks of America (ProNet access Signature PPO in TN)	PPO Network	●	●	◆	✖	■	■	■	■
Signature Health Alliance	PPO Network	●	●	◆	✖	■	■	■	■
Synergy Health Network	PPO Network and Work Comp	●	●	◆	✖	■	■	■	■
TriCare Military Services (Humana Prime Plan)	Champus Military Network	●	●	◆	✖	■			
United HealthCare	HMO, POS, PPO	●	●	◆	✖	■	■	■	■
USA Health Network (USA MCO)	PPO Network and Work Comp	●	●	◆	✖	■	■	■	■
Windsor	Medicare HMO	●	●	◆	✖	■	■	■	■
Windsor - Geopsych		●			✖				
Medicare Advantage Plans PFFS-Do Not Require Contracts or Networks all facilities can treat these patients.	Private Fee For Service	●	●	◆	✖	■	■	■	■

MEDITRACT®

My Custom Report

Contract Number	Contract Type	Contracting Entity	Department	Effective Date	Expiration Date	Responsible Party, Primary	Vendor Other Party
66588.12267C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	3/16/1999	03/15/2015	Melton, Anne	Hendersonville Nursing Home, LTD.
66588.12270C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	3/29/2010	03/28/2015	Melton, Anne	RAI Care Centers of Gallatin I, LLC
66588.12272C	Transfer Agreements	Sumner Regional Medical Center, LLC	Cardiology	7/30/2009	07/31/2016	Melton, Anne	Centennial Medical Center
66588.12274C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	12/20/1993	12/19/2014	Melton, Anne	NHC of Hendersonville
66588.12282C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	1/9/1995	01/08/2015	Melton, Anne	Royal Care of Westmoreland
66588.12285C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	6/1/2007	05/31/2015	Melton, Anne	Golden Living
66588.12288C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	12/20/1993	12/19/2014	Melton, Anne	Hartsville Convalescent Center
66588.12298C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	1/30/1998	01/29/2015	Melton, Anne	LifeTrust America, Inc
66588.12303C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	9/1/1999	08/31/2014	Melton, Anne	Madison Healthcare and Rehabilitation Center
66588.12310C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	9/27/1994	09/26/2014	Melton, Anne	Middle Tennessee Rehab at Sumner
66588.12313C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	12/20/1993	12/19/2014	Melton, Anne	Gallatin Health Care Associates
66588.12315C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	9/1/2006	08/31/2014	Melton, Anne	Patient Partners Surgery Center
66588.12316C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	11/21/1993	11/20/2014	Melton, Anne	Highland Manor
66588.12328C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	2/1/2000	01/31/2015	Melton, Anne	Vanderbilt Children's Hospital
66588.12331C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	10/18/1999	06/25/2015	Melton, Anne	Summit Medical Center
66588.12334C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	5/1/2011	04/30/2015	Melton, Anne	Saint Thomas Hospital
66588.12370C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	11/7/2011	11/06/2014	Melton, Anne	Riverview Regional Medical Center South
66588.12378C	Transfer Agreements	Sumner Regional Medical Center, LLC	Administration	10/26/1999	10/25/2014	Melton, Anne	Green Surgery Center, LLC

No. Of Contract: **18**

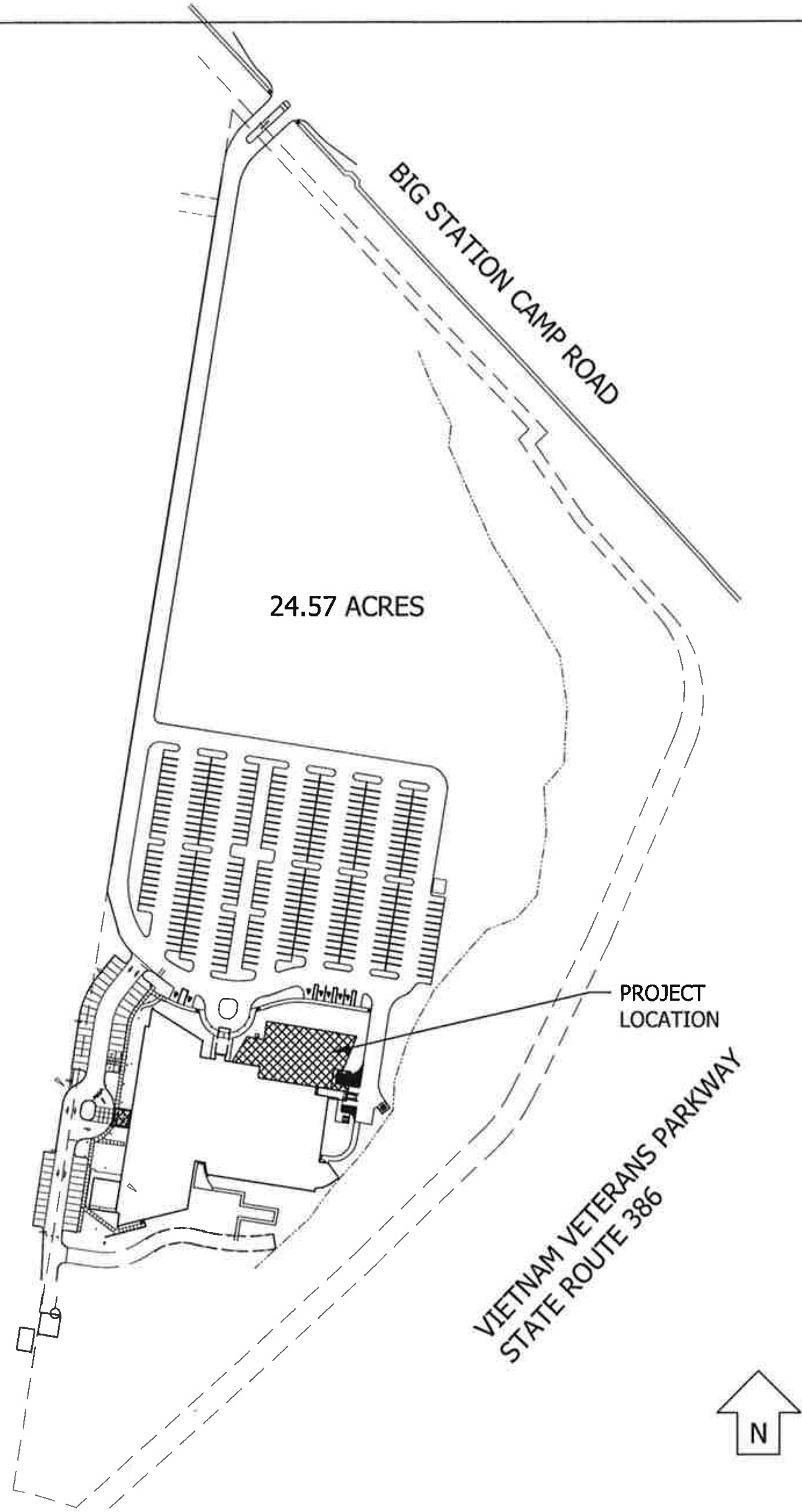
Attachment B

Plot Plan
Maps of Service Area Access
Schematics

Tab 7

Attachment B, III.(A)

Plot Plan



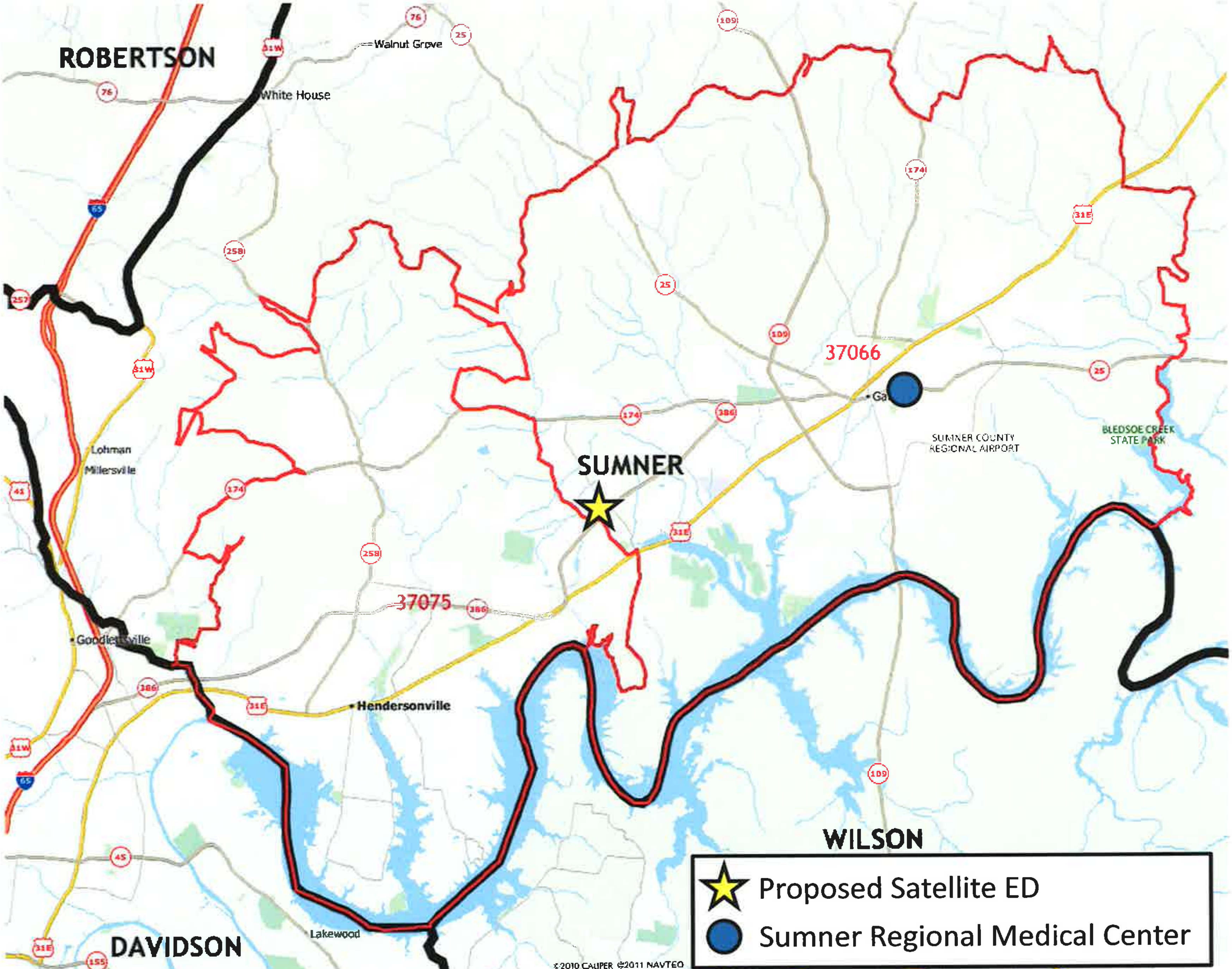
FREESTANDING EMERGENCY DEPARTMENT at SUMNER STATION for SUMNER REGIONAL MEDICAL CENTER

GALLATIN, TN 37066
08/14/2015 - C.O.N. SUBMITTAL - NOT FOR CONSTRUCTION
HMK ARCHITECTS PLLC

Tab 8

Attachment B, III.(B).1

Maps of Service Area Access


ROBERTSON
SUMNER
WILSON
DAVIDSON
37066
37075
Walnut Grove
White House
Lohman
Millersville
Goodlettsville
Hendersonville
Lakewood
SUMNER COUNTY REGIONAL AIRPORT
BLEDSOE CREEK STATE PARK
Proposed Satellite ED
Sumner Regional Medical Center
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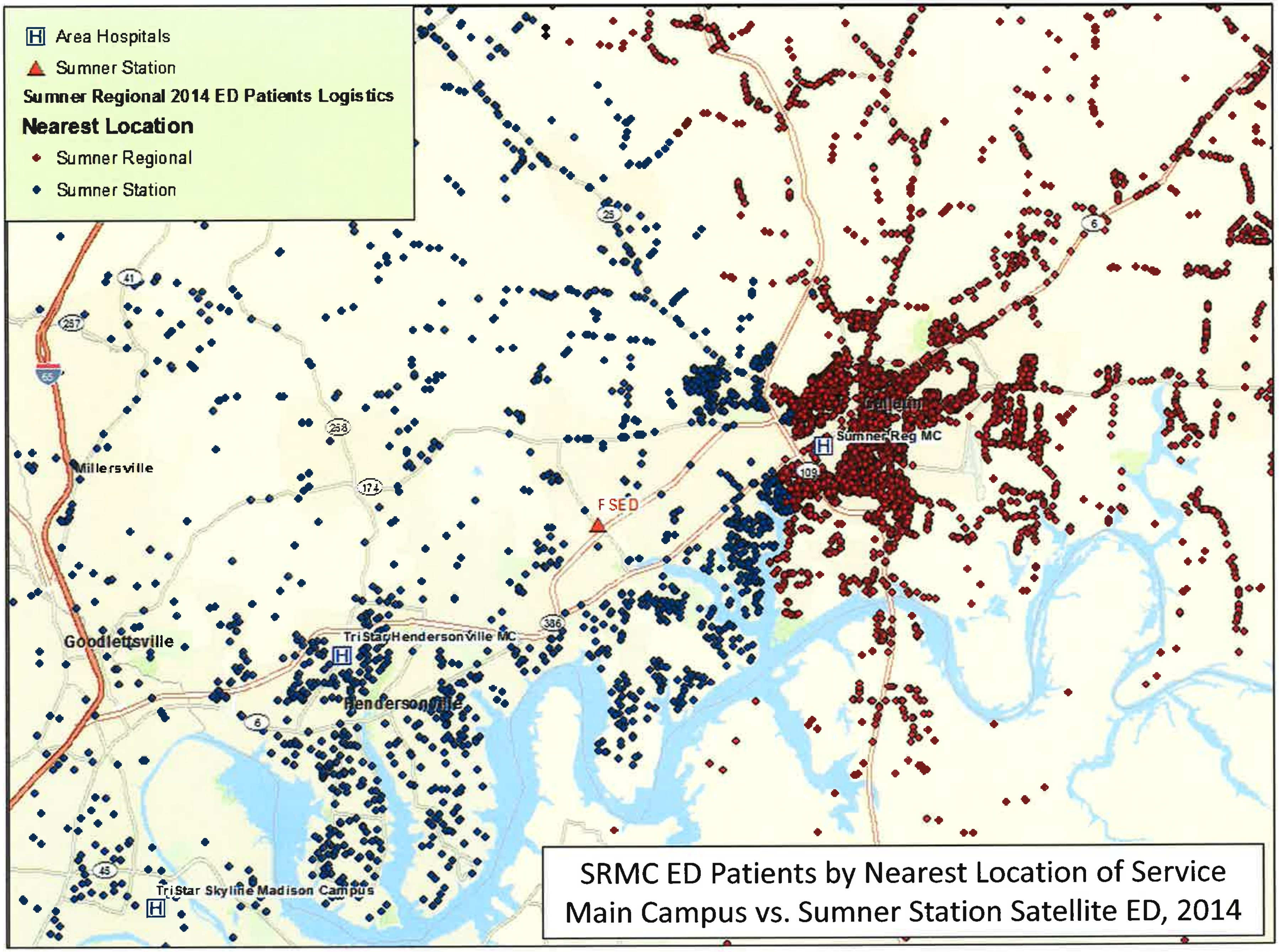
000086

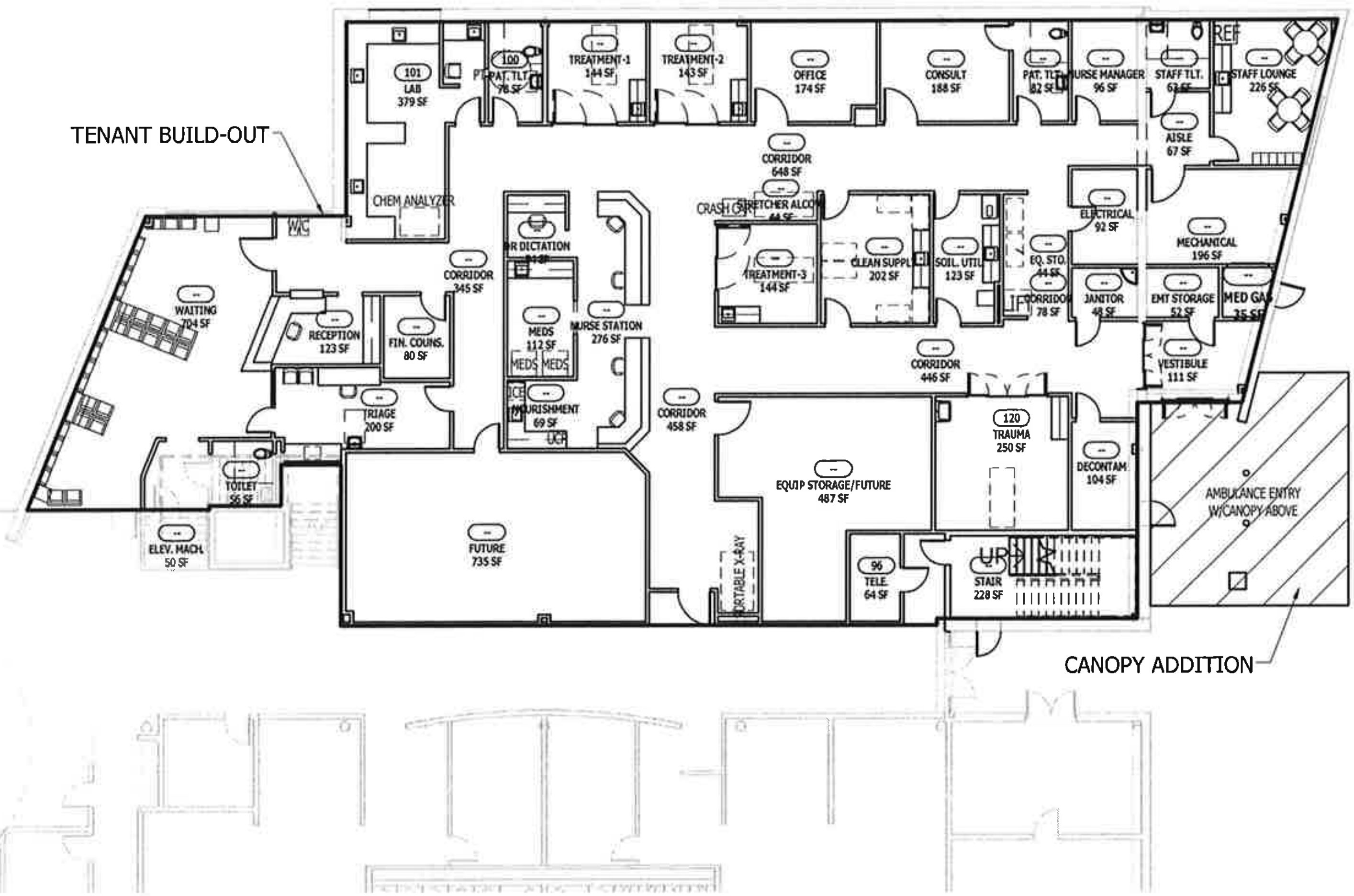


SRMC ED Patients by Nearest Location of Service
Main Campus vs. Sumner Station Satellite ED, 2014

Tab 9

Attachment B, IV

Schematics



FREESTANDING EMERGENCY DEPARTMENT at SUMNER STATION for SUMNER REGIONAL MEDICAL CENTER

GALLATIN, TN 37066

08/14/2015 - C.O.N. SUBMITTAL - NOT FOR CONSTRUCTION

HMK ARCHITECTS PLLC

TOTAL DEPT SF = 10,210 SF

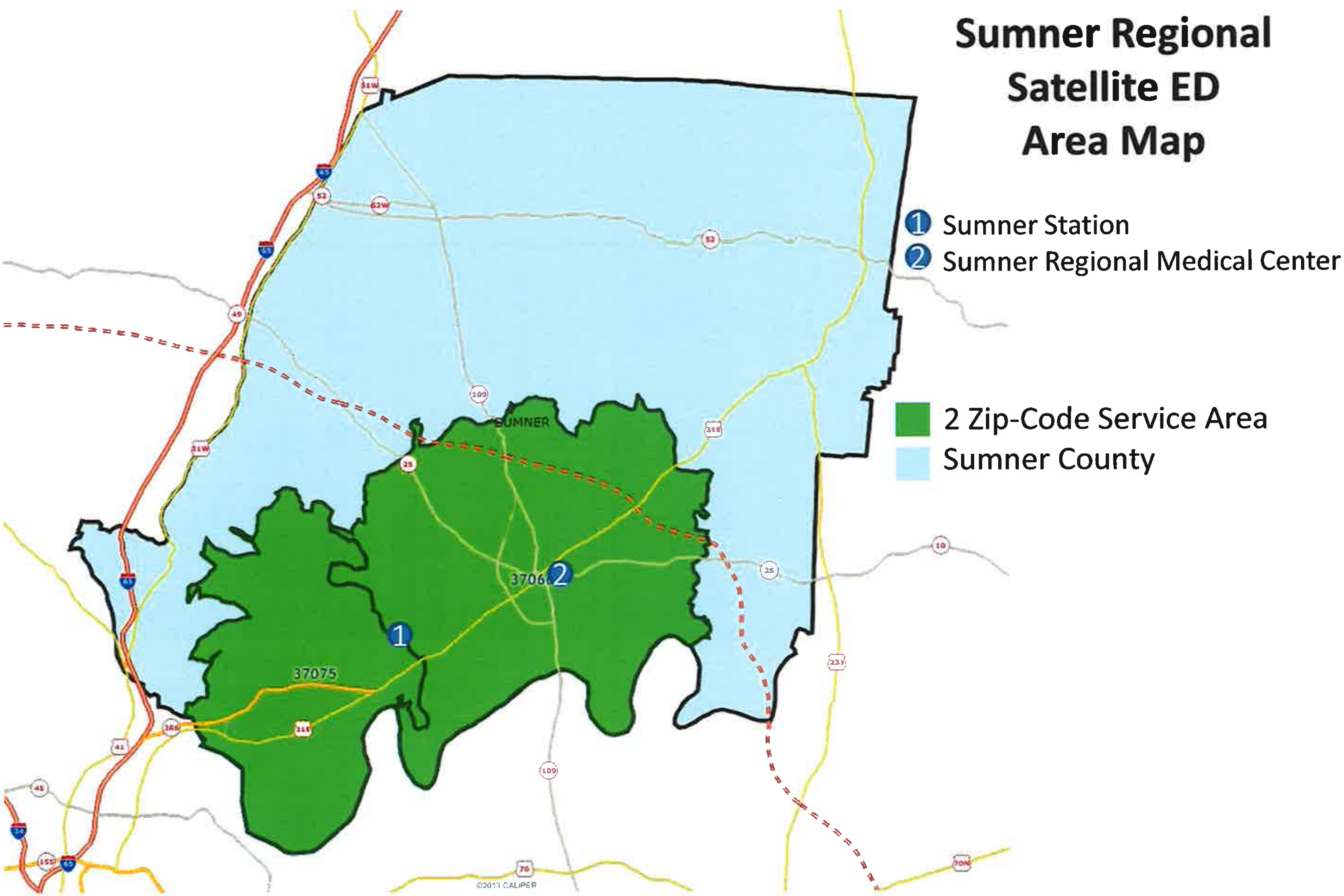
Attachment C

Service Area Map
Construction Costs Verification Letter
Verification of Funding
Balance Sheet and Income Statement
Audited Financials
Letters of Support
Physician CVs
Continuous Quality Improvement Plan
Utilization Review Plan
Patient Rights and Responsibilities
The Joint Commission Documentation
Hospital License
Inspection Report
Plan of Corrective Action

Tab 10

Attachment C
Need - 3

Service Area Map


Sumner Regional
Satellite ED
Area Map
1 Sumner Station
2 Sumner Regional Medical Center
2 Zip-Code Service Area
Sumner County
SUMNER
37066
37075
©2011 CALIPER

Tab 11

Attachment C
Economic Feasibility - 1

Construction Costs Verification Letter

HMK
ARCHITECTS PLLC

August 14, 2015

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deadrick Street, Suite 850
Nashville, TN 37243

RE: Sumner Regional Medical Center-Sumner Station Facility
Freestanding Emergency Department - Verification of Construction Cost

Dear Ms. Hill:

We have reviewed the construction cost developed for a Freestanding Emergency Department proposed for SRMC's Sumner Station facility. The construction cost of $2,940,000.00 is based on 10,210 square feet of interior renovation for the emergency department treatment rooms and its support spaces.

It is our professional opinion that the construction cost proposed which equates to $288.00 per square foot is consistent with historical data based on our experience with similar type projects. It is important to note, that our opinion is based on normal market conditions, price escalation, etc.

The project will be developed under the current codes and standards enforced by the State of Tennessee as follows:

2012 International Building Code/2012 International Mechanical Code/2012 International Plumbing Code
2012 International Gas Code
2011 National Electrical Code
2012 NFPA 1, excluding NFPA 5000
2012 NFPA 101, Life Safety Code
2010 FGI Guidelines for the Design and Construction of Health Care Facilities
2002 North Carolina Accessibility Code with 2004 Amendments/2010 Americans with Disabilities Act (ADA)

Sincerely,

HMK ARCHITECTS PLLC

Donald C. Miller, NCARB, AIA – [TN License No. 100019]

Tab 12

Attachment C
Economic Feasibility - 2

Verification of Funding

LIFEPOINT
HEALTH

August 6, 2015

Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Sumner Regional Medical Center – Certificate of Need to Open Freestanding Emergency Department

Dear Ms. Hill:

I am the Central Group Chief Financial Officer of LifePoint Health ("LifePoint"), the parent organization of Sumner Regional Medical Center ("SRMC"). This letter confirms that LifePoint has sufficient resources to fund the cost of approximately $5,603,276 for SRMC's project to open a freestanding emergency department at its Sumner Station Campus. LifePoint is committed to make these funds available to SRMC.

Thank you for your attention to this matter.

Very truly yours,

Jonathan C. Wall
Chief Financial Officer, Central Group

Tab 13

Attachment C
Economic Feasibility - 10

Balance Sheet and Income Statement

CONS - Sumner Regional Medical Center Flevel

Dec - 2014

All Entities

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Report ID: ALCFS010

Financial Statements - Balance Sheet

Month Begin	Month Change	Month Ending		Year to Date Begin	Year to Date Change	Year to Date Ending
			CURRENT ASSETS			
118,433	-194,570	-76,137	Cash & Cash Equivalents	-970,762	894,625	-76,137
			Marketable Securities			
			PATIENT ACCOUNTS RECEIVABLES			
40,096,818	-1,207,026	38,889,792	Patient Receivables	38,582,701	307,091	38,889,792
-257,617	50,086	-207,531	Less Allow for Govt Receivables	-193,527	-14,004	-207,531
-21,216,518	226,262	-20,990,256	Less Allow - Bad Debt	-17,918,152	-3,072,104	-20,990,256
18,622,683	-930,678	17,692,005	Net Patient Receivables	20,471,022	-2,779,017	17,692,005
			FINAL SETTLEMENTS			
-556,593	72,140	-484,453	Due to/from Govt Programs	-586,317	101,864	-484,453
-37,829	0	-37,829	Allowances Due Govt Programs	-38,444	615	-37,829
-594,422	72,140	-522,282	Net Final Settlements	-624,761	102,479	-522,282
18,028,261	-858,538	17,169,723	Net Accounts Receivables	19,846,261	-2,676,538	17,169,723
3,459,940	16,114	3,476,054	Inventories	3,103,738	372,316	3,476,054
842,572	-209,665	632,907	Prepaid Expenses	2,007,424	-1,374,517	632,907
245,929	78,229	324,158	Other Receivables	359,108	-34,950	324,158
22,695,135	-1,168,430	21,526,705	Total Current Assets	24,345,769	-2,819,064	21,526,705
			PROPERTY, PLANT & EQUIPMENT			
6,872,700	0	6,872,700	Land	6,872,700	0	6,872,700
114,417,915	73,948	114,491,863	Bldgs & Improvements	114,417,915	73,948	114,491,863
35,535,166	224,142	35,759,308	Equipment - Owned	29,728,094	6,031,214	35,759,308
			Equipment - Capital Leases			
3,076,208	967,790	4,043,998	Construction In Progress	639,547	3,404,451	4,043,998
159,901,989	1,265,880	161,167,869	Gross PP&E	151,658,256	9,509,613	161,167,869
-36,172,102	-693,409	-36,865,511	Less Accumulated Depreciation	-28,865,173	-8,000,338	-36,865,511
123,729,887	572,471	124,302,358	Net PP&E	122,793,083	1,509,275	124,302,358
			OTHER ASSETS			
			Investments			
9,501	0	9,501	Notes Receivable	0	9,501	9,501
25,810,693	-45,200	25,765,493	Intangible Assets - Net	26,363,719	-598,226	25,765,493
			Investments In Subsidiaries			
153,546	28,481	182,027	Other Assets	100	181,927	182,027
25,973,740	-16,719	25,957,021	Total Other Assets	26,363,819	-406,798	25,957,021
172,398,762	-612,678	171,786,084	Grand Total Assets	173,502,671	-1,716,587	171,786,084
			CURRENT LIABILITIES			
4,514,002	667,221	5,181,223	Accounts Payable	2,772,891	2,408,314	5,181,205
3,494,991	350,550	3,845,541	Accrued Salaries	3,880,706	-35,165	3,845,541
1,560,882	92,720	1,653,602	Accrued Expenses	1,722,136	-68,534	1,653,602
			Accrued Interest			
			Distributions Payable			
469,598	14,800	484,398	Curr Port - Long Term Debt	329,625	154,773	484,398
376,482	-1,017,066	-640,584	Other Current Liabilities	637,544	-1,278,128	-640,584
			Income Taxes Payable			
10,415,955	108,225	10,524,180	Total Current Liabilities	9,342,902	1,181,260	10,524,162
			LONG TERM DEBT			
3,088,833	99,244	3,188,077	Capitalized Leases	3,672,475	-484,398	3,188,077
139,355,984	-1,138,654	138,217,330	Inter/Intra Company Debt	142,943,298	-4,725,968	138,217,330
			Other Long Term Debts			
142,444,817	-1,039,410	141,405,407	Total Long Term Debts	146,615,773	-5,210,366	141,405,407
			DEFFERED CREDITS AND OTHER LIAB			
			Professional Liab Risk			
			Deferred Incomes Taxes			
203,816	28,640	232,456	Long-Term Obligations	23,075	209,381	232,456
203,816	28,640	232,456	Total Other Liabilities & Def	23,075	209,381	232,456
			EQUITY			
			Common Stock - par value			
			Capital in Excess of par value			
17,520,922	0	17,520,922	Retained Earnings - current yr	17,520,916	2,103,125	19,624,041
1,813,252	289,867	2,103,119	Net Income Current Year	0	0	0
			Distributions			
			Other Equity			
19,334,174	289,867	19,624,041	Total Equity	17,520,921	2,103,138	19,624,059
172,398,762	-612,678	171,786,084	Total Liabilities and Equity	173,502,671	-1,716,587	171,786,084

CONS - Sumner Regional Medical Center Flevel

Dec - 2014

All Entities

Financial Statements - P & L Statement

8/12/2015 01:31:08 PM

Report ID: ALCFS011

Month: Prior Yr	Month: Actual	Month: Budget	Month: Bud Var	Month: Bud Var %		Year to Date: Prior Yr	Year to Date: Actual	Year to Date: Budget	Year to Date: Bud Var	Year to Date: Bud Var %
					REVENUES					
2,830	3,431	3,603	(171)	-4.76%	Inpatient Revenue Routine Services	36,491	37,809	42,310	(4,500)	-10.64%
18,487	21,481	19,096	2,386	12.49%	Inpatient Revenue Ancillary Services	201,677	241,071	224,264	16,808	7.49%
22,154	26,390	25,697	693	2.70%	Outpatient Gross Revenue	269,683	279,276	308,605	(29,329)	-9.50%
21,317	24,913	22,698	2,214	9.76%	Inpatient Gross Revenue	238,168	278,881	266,573	12,308	4.62%
81	187	148	40	26.91%	Other Revenue	1,090	2,165	1,209	956	79.06%
43,471	51,303	48,395	2,907	6.01%	Total Patient Revenue	508,052	558,157	575,178	(17,021)	-2.96%
43,551	51,490	48,543	2,947	6.07%	Gross Revenue	509,142	560,322	576,387	(16,066)	-2.79%
					REVENUE DEDUCTIONS					
8,553	12,018	11,431	587	5.13%	Total CY CA - Medicare (1,2)	124,666	135,659	135,227	433	0.32%
(184)	(385)	(365)	(20)	-5.50%	Total CY CA - Medicaid (3)	(3,744)	(2,929)	(4,406)	1,477	33.53%
219	198	211	(14)	-6.45%	Total CY CA - Champus (6)	1,964	3,583	2,567	1,016	39.59%
	1		1		Prior Year Contractuals	265	259		259	
18,333	22,282	20,190	2,093	10.36%	Total CY CA - Mgd Care (7,8,9,12,13)	210,573	237,048	240,043	(2,995)	-1.25%
438	932	708	223	31.52%	Charity	9,247	7,251	11,788	(4,536)	-38.48%
2,026	1,929	2,112	(183)	-8.67%	Bad Debt	24,814	22,525	25,129	(2,604)	-10.36%
3,925	4,046	2,793	1,254	44.88%	Other Deductions	20,064	35,606	33,696	1,911	5.67%
33,310	41,020	37,080	3,940	10.63%	Total Revenue Deductions (Incl Bad Debt	387,868	439,003	444,042	(5,039)	-1.13%
10,241	10,470	11,463	(993)	-8.66%	Cash Revenue	121,274	121,318	132,345	(11,026)	-8.33%
					OPERATING COSTS					
3,932	3,916	4,404	(488)	-11.09%	Salaries and Wages	45,378	47,016	49,197	(2,181)	-4.43%
9	123	10	112	1,093.28%	Contract Labor	450	781	431	350	81.33%
708	794	861	(67)	-9.86%	Employee Benefits	9,018	9,697	9,715	(19)	-0.19%
1,486	1,698	1,355	343	25.34%	Supply Expense	17,517	18,183	17,718	465	2.63%
307	495	346	149	43.23%	Professional Fees	3,510	5,483	4,340	1,143	26.34%
417	584	862	(278)	-32.24%	Contract Services	5,791	7,083	7,162	(78)	-1.09%
318	198	313	(115)	-36.70%	Repairs and Maintenance	3,890	4,033	4,096	(63)	-1.54%
(1,896)	90	110	(20)	-18.27%	Rents and Leases	(761)	1,306	1,125	181	16.05%
223	219	238	(19)	-7.79%	Utilities	2,743	3,105	2,899	206	7.12%
48	64	82	(18)	-21.75%	Insurance	692	778	901	(122)	-13.57%
					Investment Income					
508	454	480	(25)	-5.27%	Non-Income Taxes	5,962	5,893	6,044	(151)	-2.50%
340	326	245	81	33.28%	Other Operating Expense	2,727	944	1,892	(948)	-50.10%
6,399	8,962	9,325	(363)	-3.90%	Cash Expense	96,916	104,303	105,520	(1,217)	-1.15%
3,842	1,508	2,138	(630)	-29.47%	EBITDA	24,357	17,016	26,825	(9,809)	-36.57%
					CAPITAL AND OTHER COSTS					
679	693	783	(89)	-11.43%	Total Depreciation	8,501	8,547	8,802	(255)	-2.89%
					Total Amortization					
					Other Non-Operating Expenses					
367	408	408	0	0.00%	Mgmt Fees and Markup Cost	4,408	4,892	4,892	0	0.00%
126	117	150	(33)	-21.87%	Interest Expense	1,755	1,474	1,748	(274)	-15.70%
					Minority Interest					
1,173	1,218	1,340	(122)	-9.12%	Total Capital and Others	14,663	14,913	15,442	(529)	-3.43%
2,670	290	798	(508)	-63.65%	Pretax Income	9,694	2,103	11,383	(9,280)	-81.52%
					TAXES ON INCOME					
					Federal Income Taxes					
					State Income Taxes					
					Total Taxes on Income					
2,670	290	798	(508)	-63.65%	Net Income	9,694	2,103	11,383	(9,280)	-81.52%
					VOLUME STATS					
665	805	615	190	30.89%	Admissions	7,485	8,154	7,790	364	4.67%
93	103	92	11	11.69%	Average Daily Census	88	101	92	9	9.95%
5,901	6,569	6,089	480	7.88%	Adjusted Patient Days	68,855	73,758	72,322	1,436	1.99%
1,356	1,658	1,311	346	26.42%	Adjusted Admissions	15,967	16,319	16,808	(489)	-2.91%
190	212	196	15	7.88%	AADC	189	202	198	4	1.99%
680	738	723	15	2.07%	Total Surgeries / Pain Cases	8,118	8,179	8,608	(429)	-4.98%
3,370	3,826	3,606	220	6.10%	Emergency Room Visits	38,406	37,147	39,994	(2,847)	-7.12%
4,472	5,658	5,874	(216)	-3.68%	Outpatient Visits	68,092	59,251	76,357	(17,106)	-22.40%
					LABOR PRODUCTIVITY					
45.39%	46.16%	46.20%	(0.04)%	-0.08%	Total Personnel % Cash Rev	45.23%	47.39%	44.84%	2.55%	5.69%
3,428	2,915	4,039	(1,123)	-27.82%	Total Personnel Costs/AA	3,435	3,523	3,531	(8)	-0.21%
788	736	870	(134)	-15.41%	Total Personnel Costs/APD	797	779	821	(41)	-5.00%
856	848	954	(106)	-11.14%	Total FTEs - Employed & Contract	836	868	916	(47)	-5.18%
4.50	4.00	4.86	(0.86)	-17.64%	EEOB	4.43	4.30	4.62	(0.32)	-7.03%
9	123	10	112	1,093.28%	Contract Labor	450	781	431	350	81.33%
					FINANCIAL STATISTICS					
14.51%	16.22%	11.82%	4.40%	37.23%	Supplies % Cash Rev	14.44%	14.99%	13.39%	1.60%	11.95%
252	258	222	36	16.19%	Supplies/APD	254	247	245	2	0.63%
1,096	1,024	1,033	(9)	-0.86%	Supplies/AA	1,097	1,114	1,054	60	5.70%
63	55		55		Net Days - Net Patient Revenue	63	55		55	
62.48%	85.60%	81.35%	4.25%	5.22%	Total Operating Expense/Cash Rev	79.92%	85.97%	79.73%	6.24%	7.83%
1,084	1,364	1,531	(167)	-10.92%	Cash Expense / APD	1,408	1,414	1,459	(45)	-3.08%
4,719	5,406	7,112	(1,706)	-23.98%	Cash Expense / AA	6,070	6,391	6,278	114	1.81%
37.52%	14.40%	18.65%	(4.25)%	-22.77%	EBDITA % CR	20.08%	14.03%	20.27%	(6.24)%	-30.80%
1,735	1,594	1,882	(289)	-15.34%	Cash Revenue/APD	1,761	1,645	1,830	(185)	-10.12%
7,552	6,316	8,742	(2,426)	-27.76%	Cash Revenue/AA	7,595	7,434	7,874	(440)	-5.58%
19.78%	18.42%	18.42%	0.00%	-0.01%	Bad Debt % Cash Rev	20.46%	18.57%	18.99%	(0.42)%	-2.22%
23.07%	25.08%	23.17%	1.91%	8.26%	Bad Debt & Charity % Adj CR	26.04%	23.11%	25.61%	(2.50)%	-9.76%
51.20%	51.32%	47.49%	3.83%	8.07%	Poli[illegible] Pat Rev	45.40%	48.85%	47.59%	1.26%	2.64%

Tab 14

Attachment C
Economic Feasibility - 10

Audited Financials

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2014

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 000-51251

LifePoint Hospitals, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware *(State or Other Jurisdiction of Incorporation or Organization)*	**20-1538254** *(I.R.S. Employer Identification No.)*
330 Seven Springs Way **Brentwood, Tennessee** *(Address Of Principal Executive Offices)*	**37027** *(Zip Code)*

(615) 920-7000

(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, par value $.01 per share	NASDAQ Global Select Market
Preferred Stock Purchase Rights	NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer ☑	Accelerated filer ☐	Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☑

The aggregate market value of the shares of registrant's Common Stock held by non-affiliates as of June 30, 2014, was approximately $2.2 billion.

As of February 6, 2015, the number of outstanding shares of the registrant's Common Stock was 44,198,634.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2015 annual meeting of stockholders are incorporated by reference into Part III of this report.

LifePoint Hospitals, Inc.

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PART I

Item 1. *Business.*

Overview of Our Company

LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, operates general acute care hospitals primarily in non-urban communities in the United States ("U.S."). Unless the context otherwise requires, LifePoint and its subsidiaries are referred to herein as "LifePoint," the "Company," "we," "our" or "us." At December 31, 2014, on a consolidated basis, we operated 67 hospital campuses in 21 states, having a total of 8,254 licensed beds. Effective January 1, 2015, we sold Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville") located throughout northwest Alabama. Upon completion of this sale, we operated 64 hospital campuses in 21 states, having a total of 8,024 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated $4,483.1 million, $3,678.3 million and $3,391.8 million in revenues during the years ended December 31, 2014, 2013 and 2012, respectively.

Our hospitals typically provide the range of medical and surgical services commonly available in hospitals in non-urban markets. These services include general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation services, pediatric services, and, in some of our hospitals, specialized services such as open-heart surgery, skilled nursing, psychiatric care and neuro-surgery. In many markets, we also provide outpatient services such as same-day surgery, laboratory, x-ray, respiratory therapy, imaging, sports medicine and lithotripsy. The services provided at any specific hospital depend on factors such as community need for the service, whether physicians necessary to operate the service line safely are members of the medical staff of that hospital, whether the service might be supported by community residents, and any contractual or certificate of need restrictions that exist. Like most hospitals located in non-urban markets, our hospitals do not engage in extensive medical research and medical education programs. However, six of our hospitals have affiliations with medical schools, including the clinical rotation of medical and pharmacy students, and two of our hospitals own and operate schools of nursing and other allied health professions.

We seek to fulfill our mission of Making Communities Healthier® by striving to (1) improve the quality and types of healthcare services available in our communities; (2) provide physicians with a positive environment in which to practice medicine, with access to necessary equipment and resources; (3) develop and provide a positive work environment for employees; (4) expand each hospital's role as a community asset; and (5) improve each hospital's financial performance. We expect our hospitals to be the place where patients choose to come for care, where physicians want to practice medicine and where employees want to work.

Business Strategy

Opportunities in Existing Markets

We believe that growth opportunities remain in our existing markets. Growth at our hospitals is dependent in part on how successful our hospitals are in their efforts to recruit physicians to their respective medical staffs, whether those physicians are active members of their respective medical staffs over a long period of time and whether and to what extent members of our hospitals' medical staffs admit patients to our hospitals or utilize our outpatient service lines.

We believe that growth at our hospitals is dependent in part on the quality of care provided in our facilities, adding new service lines in our existing markets and investing in new technologies desired by physicians and patients. The quality of healthcare services provided at our hospitals is an increasingly important factor to patients when deciding where to seek care, to physicians when deciding where to practice and to governmental and private third party payors when determining the reimbursement that is paid to our hospitals. Because in virtually every case the Centers for Medicare and Medicaid Services ("CMS") core measure scores and other quality measures, such as Hospital Consumer Assessment of Healthcare Providers & Systems ("HCAHPS") scores, 30-day readmission rates, patient falls and adverse drug events, ascribed to our hospitals are impacted by the practice decisions of the physicians on our hospital medical staffs, we have implemented strategies to educate and partner with medical staff members to improve scores at our hospitals, especially those that are below our average or below management's expectation. We are committed to further improving our hospitals' quality scores through targeted strategies, including increased education and engagement campaigns, clinical decision support tools, subject matter expert facilitation and hospital-specific action plans.

Additionally, in most of our markets, a significant portion of patients who require services available at acute care hospitals leave our markets to receive such care. We believe this presents an opportunity for growth, and we are working with the hospitals in communities where this phenomenon exists to implement new strategies or enhance existing strategies to attract patients. We regularly conduct operating reviews of our hospitals to pinpoint new service lines that allow residents of our communities to receive healthcare services closer to home. When such needed service lines are identified, we focus on recruiting the physicians necessary to operate such service lines appropriately. For example, our hospitals have responded to physician interest in requests for hospitalists by introducing or strengthening hospitalist programs where appropriate. Our hospitals have taken other steps to allow more community residents to receive appropriate care close to home, such as structured efforts to solicit input from medical staff members and to respond promptly to legitimate unmet physician needs for necessary equipment or trained support staff.

While responsibly managing our operating expenses, we have also made significant, targeted investments in our hospitals to add new technologies, modernize facilities and expand the services available. These investments should assist in our efforts to attract and retain physicians, to offset outmigration of patients and to make our hospitals more desirable to our employees and potential patients. More recently, economic factors including, potentially, self-rationing of healthcare services, among other factors, seem to have made it more difficult to increase the number of patients who seek care at many of our hospitals.

Opportunities in New Markets

We believe that strategic acquisitions and partnerships can supplement our efforts to achieve organic growth in our existing markets, and in the past couple of years, newly acquired hospitals have accounted for the majority of our growth. We continue to focus on strategic growth through acquisition and integration of well-positioned hospitals in growing areas of the U.S. where valuations are attractive and we can identify opportunities for improved financial performance through our management and strategic initiatives. We are also focused on developing strategic partnerships with not-for-profit healthcare providers to achieve growth in new regions. We believe that such opportunities remain strong as community hospitals continue to see the benefits of scale and the additional resources available through a partnership with a large organization such as ours. We believe that the additional regulatory burdens imposed by healthcare reform initiatives are also causing hospitals to pursue strategic acquisitions and partnerships.

In 2011, we formed Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-controlled affiliate of Duke University Health System, Inc. ("Duke"), with a mission to own and operate community hospitals as well as improve the delivery of healthcare services. We own a controlling interest in Duke LifePoint Healthcare. We believe this partnership, which combines our operational resources and experience with Duke's expertise in the development of clinical services and quality systems, further strengthens our ability to acquire well-positioned hospitals. Since its formation in 2011, we have completed the acquisition of twelve acute care hospitals through Duke LifePoint Healthcare. Additionally, in 2012, we entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Healthcare Network of Kentucky and Southern Indiana ("RHN"), the purpose of which is to own and operate hospitals in non-urban communities in Kentucky and Southern Indiana. Through RHN, we acquired Scott Memorial Hospital ("Scott Memorial"), a 25 bed critical access hospital located in Scottsburg, Indiana, effective January 1, 2013.

Acquisitions

During the years ended December 31, 2014, 2013 and 2012, through Duke LifePoint Healthcare, we acquired:

- Conemaugh Health System ("Conemaugh"), which is comprised of Conemaugh Memorial Medical Center, a 470 bed acute care hospital, 39 bed rehabilitation facility and 30 bed long-term care facility located in Johnstown, Pennsylvania, Meyersdale Medical Center ("Meyersdale"), a 20 bed critical access hospital located in Meyersdale, Pennsylvania, and Miners Medical Center, a 30 bed acute care hospital located in Hastings, Pennsylvania, effective September 1, 2014;
- Haywood Regional Medical Center ("Haywood"), a 169 bed acute care hospital located in Clyde, North Carolina, effective August 1, 2014;
- WestCare Health System ("WestCare"), which is comprised of Harris Regional Hospital, an 86 bed acute care hospital located in Sylva, North Carolina, and Swain County Hospital, a 48 bed critical access hospital located in Bryson City, North Carolina, effective August 1, 2014;
- an 80% interest in an entity that owns and operates Rutherford Regional Hospital ("Rutherford"), a 143 bed acute care hospital located in Rutherfordton, North Carolina, effective June 1, 2014;
- an 80% interest in an entity that owns and operates Wilson Medical Center ("Wilson"), a 294 bed hospital and 90 bed long-term care facility located in Wilson, North Carolina, effective March 1, 2014;
- Marquette General Hospital ("Marquette General"), a 307 bed hospital system located in Marquette, Michigan, effective September 1, 2012; and
- an 80% interest in an entity that owns and operates Twin County Regional Hospital ("Twin County"), a 141 bed hospital located in Galax, Virginia, effective April 1, 2012.

Additionally, during the years ended December 31, 2013 and 2012, we acquired:

- Bell Hospital ("Bell"), a 25 bed critical access hospital located in Ishpeming, Michigan, effective December 1, 2013;
- an 80% interest in an entity that owns and operates Portage Health ("Portage"), a 36 bed hospital and 60 bed long-term care facility located in Hancock, Michigan, effective December 1, 2013;
- an 80% interest in an entity that owns and operates Fauquier Health ("Fauquier"), a 97 bed hospital and 113 bed long-term care facility located in Warrenton, Virginia, effective November 1, 2013; and
- Woods Memorial Hospital ("Woods Memorial"), a 72 bed hospital and 88 bed long-term care facility located in Etowah, Tennessee, effective July 1, 2012. Effective December 1, 2013, the operations of Woods Memorial were consolidated into Athens Regional Medical Center located in Athens, Tennessee to form Starr Regional Medical Center.

Cost Management

We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated hospitals.

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises.

Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We owned an approximate 4.6% equity interest in this group purchasing organization at December 31, 2014.

Operations

We seek to operate our hospitals in a manner that positions them to compete effectively and to further our mission of Making Communities Healthier®. The operating strategies of our hospitals are determined largely by local hospital leadership and are tailored to each of their respective communities. Generally, our overall operating strategy is to: (1) expand the breadth of services offered at our hospitals in an effort to attract community patients that might otherwise leave their community for healthcare; (2) recruit, attract and retain physicians interested in practicing in the non-urban communities where our hospitals are primarily located; (3) recruit, retain and develop hospital executives and staff interested in working and living in the non-urban communities where our hospitals are primarily located; (4) negotiate favorable, facility-specific contracts with managed care and other private third-party payors; and (5) efficiently leverage resources across all of our hospitals. In appropriate circumstances, we may selectively acquire hospitals or other healthcare facilities where our operating strategies can improve performance.

As of December 31, 2014, with the exception of certain of our critical access hospitals, including Bluegrass Community Hospital ("Bluegrass"), Bell and Meyersdale, all of our hospitals are accredited by the Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are, therefore, eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. Bluegrass, Bell and Meyersdale participate in the Medicare program by otherwise meeting the Medicare Conditions of Participation.

Services Provided and Peer Review

The range of services that can be offered at any of our hospitals depends significantly on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no long-term contractual relationship with us. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by a hospital's local governing board. Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals, and in many cases, credentialed (or authorized) to provide specialized services by the medical executive (or other comparable) committees of the hospitals and the local governing boards. The medical executive or other applicable committees are generally comprised of physicians on a hospital's medical staff, and the boards generally include members of a hospital's medical staff as well as community leaders. In addition to medical staff credentialing decisions, these boards establish policies concerning medical, professional and ethical practices, monitor these practices, and are responsible for reviewing these practices in order to determine that they conform to established standards of proper and appropriate medical care. Although we maintain quality assurance programs to support and monitor quality of care standards and to meet accreditation and regulatory requirements, decisions about whether physicians can practice at our hospitals, the scope of each such physician's practice, the oversight of the quality of the care being provided by such physicians, and physician disciplinary or corrective actions are made or are the responsibility of the medical executive, peer review, quality assurance, utilization review, and other related medical staff committees and the local governing boards at each hospital. As a result, our ability to address quality of care and performance concerns relating to non-employed physicians may be limited. We also monitor patient care evaluations and other quality of care assessment activities on a regular basis.

Members of the medical staffs of our hospitals are free to serve on the medical staffs of hospitals not owned or operated by LifePoint. Members of our medical staffs are free to terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. Although we own a number of physician practices and, where permitted by law, employ some physicians, the majority of the physicians who practice at our hospitals are not our employees. It is essential to our ongoing business that we attract and retain skilled employees and an appropriate number of quality physicians and other healthcare professionals in all specialties on our medical staffs.

In our markets, physician recruitment and retention are affected by a shortage of physicians in certain sought-after specialties, the difficulties that physicians are experiencing in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance, and the challenges that can be associated with practicing medicine in small groups or independently.

Availability of Information

Our website is *www.lifepointhospitals.com.* We make available free of charge on this website under "Investor Relations — SEC Filings" our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished as soon as reasonably practicable after we electronically file such materials with, or furnish them to, the U.S. Securities and Exchange Commission ("SEC").

Sources of Revenue

Our hospitals receive payment for patient services from the federal government primarily under the Medicare program, state governments under their respective Medicaid programs, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers, as well as directly from patients ("self-pay").

Our revenues by payor and approximate percentages of revenues during the years specified below were as follows (in millions):

	2014		2013		2012	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Medicare	$1,361.4	30.4%	$1,199.5	32.6%	$1,170.3	34.5%
Medicaid	619.8	13.8	517.0	14.1	494.6	14.6
HMOs, PPOs and other private insurers	2,476.7	55.2	1,876.1	51.0	1,645.5	48.5
Self-pay	744.9	16.6	766.5	20.8	653.9	19.3
Other	98.1	2.2	69.6	1.9	51.9	1.5
Revenues before provision for doubtful accounts	5,300.9	118.2	4,428.7	120.4	4,016.2	118.4
Provision for doubtful accounts	(817.8)	(18.2)	(750.4)	(20.4)	(624.4)	(18.4)
Revenues	$4,483.1	100.0%	$3,678.3	100.0%	$3,391.8	100.0%

Patients generally are not responsible for any difference between customary hospital charges and amounts reimbursed for the services under Medicare, Medicaid, private insurance plans, HMOs or PPOs, but are responsible for services not covered by these plans, exclusions, deductibles or co-payment features of their coverage. The amounts of exclusions, deductibles and co-payments generally have been increasing each year as employers have been shifting a higher percentage of healthcare costs to employees. During the year ended December 31, 2014, our self-pay revenues decreased primarily as a result of a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. At December 31, 2014, only eight of the states in which we operate are currently implementing expansions to their Medicaid programs. These reductions partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who choose not to purchase insurance or who purchase insurance plans with high deductibles and high co-payments.

Medicare

Our revenues from Medicare were approximately $1,361.4 million, or 30.4% of total revenues for the year ended December 31, 2014. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal disease. All of our hospitals are currently certified as providers of Medicare services. Amounts received under the Medicare program are often significantly less than the hospital's customary charges for the services provided. Since 2003, Congress and CMS have made several sweeping changes to the Medicare program and its reimbursement methodologies, such as the implementation of the prescription drug benefit that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA") and the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"). Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 ("ATRA") required further reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposed a 2% reduction in Medicare spending which began on April 1, 2013.

Medicare Inpatient Prospective Payment System

Under the Medicare program, hospitals are reimbursed for the costs of acute care inpatient stays under an inpatient prospective payment system ("IPPS"). Under the IPPS, our hospitals are paid a prospectively determined amount for each hospital discharge that is based on the patient's diagnosis. Specifically, each discharge is assigned to a Medicare severity diagnosis related group ("MS-DRG"), which groups patients that have similar clinical conditions and that are expected to require a similar amount of hospital resources. Each MS-DRG is, in turn, assigned a relative weight that is prospectively set and that reflects the average amount of resources, as determined on a national basis, that are needed to treat a patient with that particular diagnosis, compared to the amount of hospital resources that are needed to treat the average Medicare inpatient stay. The IPPS payment for each discharge is based on two national base payment rates or standardized amounts, one that covers hospital operating expenses and another that covers hospital capital expenses. The base MS-DRG payment rate for operating expenses has two components, a labor share and a non-labor share. Although the labor share is adjusted by a wage index to reflect geographical differences in the cost of labor, the base MS-DRG payment rate does not consider the actual costs incurred by an individual hospital in providing a particular inpatient service.

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor on an annual basis. The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For federal fiscal years ("FFYs") 2015 (which began on October 1, 2014 and will end on September 30, 2015), 2014 (which began on October 1, 2013 and ended on September 30, 2014), and 2013 (which began on October 1, 2012 and ended on September 30, 2013), the hospital market basket index increased 2.9%, 2.5%, and 2.6%, respectively. Generally, however, the percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFY 2015, FFY 2014 and FFY 2013 were reduced by CMS by 0.20%, 0.30% and 0.10%, respectively. For FFY 2012 and each subsequent fiscal year, as also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity. For FFY 2015, FFY 2014 and FFY 2013, the productivity adjustment equated to a 0.5%, 0.5% and 0.7% reduction in the market basket increase, respectively. In addition, in FFY 2013, FFY 2012 and FFY 2011, IPPS payment rates to hospitals were increased by 1.0%, decreased by 2.0% and decreased by 2.9%, respectively, for documentation and coding adjustments that were required by the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (the "TMA Act"), and decreased by 0.8% in both FFY 2015 and FFY 2014 for additional documentation and coding adjustments required by ATRA. The market basket increase for FFY 2014 was also reduced by 0.2% to offset the cost of the changes that were implemented to the Medicare program's admission and medical review criteria for hospital inpatient admissions services in connection with the "two midnight rule," which is discussed in more detail below.

From FFY 2005 through 2007, the MMA required all acute care hospitals to participate in CMS's Hospital Inpatient Quality Reporting Program (the "IQR Program") in order to receive the full hospital market basket update. Beginning in FFY 2007, the Deficit Reduction Act of 2005 (the "DRA") expanded the number of quality measures that were required to be reported and increased the reduction in reimbursement to hospitals that do not participate in the IQR Program from 0.4% to 2.0%. Beginning in FFY 2015, hospitals that do not participate in the IQR Program will lose one-quarter of the percentage in their payment updates.

Our hospitals reported all quality measures required by CMS related to the IQR Program and will receive the full market basket update through FFY 2015.

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. The MS-DRGs were phased-in over a two year period, with FFY 2009, which began on October 1, 2008, being the first year that IPPS payments to hospitals were based entirely on the new MS-DRGs.

To offset the effect of the coding and discharge classification changes that CMS believed would occur as hospitals implemented the MS-DRG system, CMS established prospective documentation and coding adjustments to the national standardized amounts of (1.2%) in FFY 2008 and (1.8%) in both FFYs 2009 and 2010. However, the TMA Act, which was enacted on September 29, 2007, effectively decreased the reductions for FFYs 2008 and 2009 to (0.6%) and (0.9%), respectively. In addition, the TMA Act required CMS to conduct a "look-back" beginning in FFY 2010 and make appropriate changes to the reduction percentages based on actual FFY 2008 and 2009 claims data. Based on its evaluation, CMS determined that IPPS payments increased by 2.5% in FFY 2008 and 5.4% in FFY 2009 due solely to the implementation of the MS-DRG System. The increases exceeded the cumulative prospective adjustments by 5.8% for FFYs 2008 and 2009. The TMA Act required CMS to recoup the increase in spending in FFYs 2008 and 2009 by FFY 2012. In the IPPS final rule for FFY 2011, CMS reduced the standardized amount by (2.9%), which represented half of the required retrospective adjustment. The remaining (2.9%) retrospective reduction was implemented in FFY 2012. However, because the (2.9%) retrospective reduction that was made in FFY 2011 was restored in FFY 2012, the retrospective adjustment that was made in FFY 2012 was essentially negated. The (2.9%) retrospective reduction that was made in FFY 2012 was restored in FFY 2013.

The TMA Act also required CMS to make an additional prospective cumulative adjustment of (3.9%) to eliminate the full effect of the documentation and coding changes on future payments. The TMA Act gave CMS discretion as to the timing of the implementation of the prospective documentation and coding adjustment, and CMS did not implement any portion of the adjustment in FFYs 2010 and 2011. CMS did, however, implement a (2.0%) prospective documentation and coding adjustment in FFY 2012 and completed the remaining (1.9%) prospective adjustment in FFY 2013.

In addition to the adjustments that were required by the TMA Act, ATRA, which was enacted on January 1, 2013, required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFY 2008 through 2013 solely as the result of the transition to the MS-DRG system and was not recaptured by the adjustments that were mandated by the TMA Act. In FFY 2014 and FFY 2015, CMS applied (0.8%) adjustments as part of the recovery process required by ATRA. CMS has indicated that it expects to make similar adjustments in FFY 2016 and FFY 2017 to recover the remaining outstanding amount.

The following tables list our historical Medicare MS-DRG and capital payments for the years presented (in millions):

	Medicare MS-DRG Payments	Medicare Capital Payments
2014	$ 585.5	$ 45.9
2013	$ 535.5	$ 41.7
2012	$ 517.0	$ 41.1

In addition to MS-DRG and capital payments, hospitals may qualify for outlier payments for cases involving patients whose treatment costs are extraordinarily high when compared to the costs of treating an average patient in the same DRG.

Hospitals may also qualify for Medicare disproportionate share hospital ("DSH") payments, if they treat a high percentage of low-income patients. The adjustment is generally based on the hospital's disproportionate patient percentage ("DPP"), which is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. Hospitals whose DPP meets or exceeds a specified threshold amount are eligible for a DSH payment adjustment. The Affordable Care Act requires Medicare DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld will be reduced by the percentage change in uninsured individuals under the age of 65 from 2013 to the current year (as normalized to reflect the October 1 commencement date for each FFY) minus 0.1% in FFY 2014 and minus 0.2% in FFY 2015 and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2015 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2015 at $7.65 billion, down from $9.05 billion in FFY 2014. Medicare DSH payments received in the aggregate by our hospitals for 2014, 2013 and 2012 were approximately $73.5 million, $67.8 million and $68.8 million, respectively.

"Two Midnight Rule"

In addition, CMS has issued the "two midnight rule," which revised its longstanding guidance to hospitals and physicians relating to when hospital inpatient admissions are deemed to be reasonable and necessary for payment under Medicare Part A and provides that, in addition to services that are designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally only appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (i) expects the beneficiary to require a stay that crosses at least two midnights and (ii) admits the beneficiary to the hospital based upon that expectation. CMS is prohibited from allowing recovery auditors to conduct inpatient hospital status reviews on claims with dates of admission October 1, 2013 through March 31, 2015, but, in the future, reviews could be conducted on claims with dates of admission after that time.

While the IPPS final rule for FFY 2014 became effective on October 1, 2013, CMS initially indicated that, for a period of 90 days after the effective date of the rule, it would not permit recovery auditors and other Medicare review contractors to review inpatient admissions of one midnight or less that began between October 1, 2013 and December 31, 2013. CMS subsequently extended that delay to inpatient admissions that occur on or prior to September 30, 2014. CMS did, however, instruct Medicare Administrative Contractors ("MACs") to review, on a pre-payment basis, a small sample (approximately 10 – 25) of inpatient hospital claims relating to admissions that occur between March 31, 2014 and September 30, 2014, and that span less than two midnights after admission in order to determine each hospital's compliance with the new inpatient admission and medical review criteria. Hospitals can rebill denied inpatient hospital admissions in accordance with the rule.

On April 1, 2014, President Obama signed the Protecting Access to Medicare Act of 2014 ("PAMA") into law. Among other things, PAMA prohibits CMS from allowing recovery auditors to conduct inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through March 31, 2015, and permits CMS to continue to allow MACs to review, on a pre-payment basis, a small sample of inpatient hospital claims relating to admissions that span less than two midnights and that occur on or after October 1, 2013 but before March 31, 2015, in order to determine hospital compliance with the new inpatient admission and medical review criteria.

On May 15, 2014, CMS solicited comments in the IPPS proposed rule for FFY 2015 regarding the development of an alternative payment methodology under the Medicare program for short inpatient hospital stays. Among other things, CMS is seeking input on how to define a short inpatient hospital stay for Medicare payment purposes and how to determine the appropriate payment amounts for short inpatient hospital stays. In the IPPS final rule for FFY 2015, CMS indicated it would consider the comments received in future rulemaking.

We cannot predict whether Congress or CMS will further delay the review of inpatient admissions of one midnight or less by recovery auditors or other Medicare review contractors or the impact that any such reviews will have on our business and results of operations when they are allowed by CMS. In addition, legislation has been introduced in Congress that, among other things, would generally prohibit Medicare review contractors from denying claims due to the length of a patient's stay or a determination that services could have been provided in an outpatient setting and require CMS to develop a new payment methodology for services that are provided during short inpatient hospital stays. Federal lawsuits have also been filed challenging the two midnight rule primarily on the grounds that the implementation of the rule itself, and the payment reduction associated with the rule (i.e., 0.2% IPPS payment reduction to hospitals) violate the Administrative Procedure Act. We cannot predict whether the legislation that has been introduced in Congress will be adopted or, if adopted, the amount of reimbursement that would be paid under any alternative payment methodology that is developed by CMS. We also cannot predict whether the federal court challenges to the two midnight rule will be successful.

Medicare Hospital Outpatient Prospective Payment System

The Balanced Budget Refinement Act of 1999 ("BBRA") established a prospective payment system for outpatient hospital services that commenced on August 1, 2000. Under Medicare's hospital outpatient prospective payment system ("OPPS"), hospital outpatient services are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for calendar years ("CYs") 2015, 2014 and 2013 were $74.144, $72.672 and $71.313, respectively, after the inclusion of the 0.7% reduction for CY 2015, the 0.8% reduction for CY 2014, and the 0.8% reduction for CY 2013 that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (the "HOPQDRP"). Hospitals that do not satisfy the reporting requirements of the HOPQDRP are subject to a reduction of 2.0% from the fee schedule increase factor. Our hospitals reported all quality measures required by CMS for HOPQDRP and will receive the full market basket update through CY 2015.

The following table lists our historical Medicare APC payments for the years presented (in millions):

	Medicare APC Payments
2014	$ 387.4
2013	$ 328.4
2012	$ 309.2

Medicare Dependent and Low Volume Hospital Programs

On December 26, 2013, the Pathway for SGR Reform Act of 2013 (the "Pathway Act") was enacted. Among other things, the Pathway Act extended through March 31, 2014, the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year. PAMA extended both of these programs through March 31, 2015. If the Medicare dependent hospital program and Medicare low volume hospital program are not extended beyond March 31, 2015, we anticipate that our reimbursement will be reduced by approximately $12.8 million for 2015.

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that follow reasonable collection efforts and remain unpaid by Medicare beneficiaries can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the fiscal intermediary from the prior cost report filing.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35%. Under this program, our hospitals received an aggregate of approximately $18.1 million, $21.7 million and $20.2 million for 2014, 2013 and 2012, respectively.

Physician Services

Physician services are reimbursed under the Medicare physician fee schedule ("PFS") system, under which CMS has assigned a national relative value unit ("RVU") to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the sustainable growth rate ("SGR")) to arrive at the payment amount for each service. While RVUs for various services may change in a given year, any alterations are required by statute to be virtually budget neutral.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula, if implemented as mandated by statute, would result in significant reductions to payments under the PFS. Since 2003, Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For CY 2014, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 20.1% to all physician payments under the PFS for CY 2014. The Pathway Act delayed application of the SGR and provided for a 0.5% increase in PFS payment rates through March 31, 2014. PAMA extended the 0.5% increase in PFS payment rates established by the Pathway Act through December 31, 2014, and also provided that there will be no increase to the CY 2015 PFS from January 1, 2015, through March 31, 2015. For the remainder of CY 2015, CMS has issued a final rule that will apply the SGR and result in a 21.2% reduction in PFS rates.

Medicaid

Our revenues under the various state Medicaid programs, including state-funded managed care programs, were approximately $619.8 million, or 13.8% of total revenues for the year ended December 31, 2014. These payments are typically based on fixed rates determined by the individual states. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. For 2014, 2013 and 2012, our revenues attributable to DSH and other supplemental payments were approximately $155.7 million, $128.7 million and $119.7 million, respectively. The increase in revenues from DSH and other supplemental payments is primarily attributable to additional funding provided by certain states, which was made available in part by additional annual state provider taxes on certain of our hospitals and changes in classification of state programs.

Medicaid programs are funded by both the federal government and state governments to provide healthcare benefits to certain low-income individuals and groups. These programs and the reimbursement methodologies are administered by the states and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement programs, or some combination of these three methods.

Many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

Annual Cost Reports

Hospitals participating in the Medicare and some Medicaid programs, whether paid on a reasonable cost basis or under a prospective payment system, are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and some Medicaid programs are subject to routine governmental audits. These audits may result in adjustments to the amounts ultimately determined to be payable to us under these reimbursement programs. Finalization of these audits often takes several years. Providers may appeal any final determination made in connection with an audit.

Recovery Audit Contractors

In 2005, CMS began using recovery audit contractors ("RACs") to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify Medicare overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. RACs have the authority to look back at claims up to five years old, provided that the claim was paid on or after October 1, 2007. Any claims identified as overpayments are subject to a RAC program appeals process. The RAC program began as a demonstration project in five states and was made permanent by the Tax Relief and Health Care Act of 2006. The permanent RAC program was gradually expanded across the U.S. in 2008 and 2009 and is currently operating in all 50 states. The Affordable Care Act further expanded the use of RACs and required each state to establish a Medicaid RAC program by January 1, 2012.

The original recovery audit contracts expired in February 2014, and CMS is in the process of procuring new agreements for the RAC program. However, a number of pre and post-award contests have been filed in connection with the procurement process, due, in large part, to the payment and other reforms CMS is attempting to implement to the RAC program through the new contracts, and it is unlikely that any of those contests will be resolved prior to the second half of 2015. As a result, CMS has extended, on a limited basis, the current recovery audit contracts through December 31, 2015, but is only allowing the RACs to conduct certain automated reviews and a limited number of complex reviews on topics that are selected by CMS.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various state Medicaid RAC programs to which our hospitals will be subject. In September 2014, in response to concerns that the Medicare program's denials of reimbursement for short-term care have caused a significant growth in claim appeals, CMS announced that it was offering an administrative agreement to any hospital willing to withdraw its pending appeals in exchange for timely partial payment in an amount equal to 68% of the net allowable amount of the claims at issue. During the year ended December 31, 2014, we participated in that administrative agreement and withdrew certain of our pending appeals for claims previously denied under the RAC program in exchange for payments that resulted in an increase to revenue of approximately $4.5 million. Additionally, during the year ended December 31, 2014, we were successful in appealing many of our previous adverse RAC determinations. Accordingly, during the year ended December 31, 2014, including both our participation in the CMS administrative agreement, as well as our success in appealing adverse RAC determinations, we recognized additional revenue of approximately $9.1 million. During the years ended December 31, 2013 and 2012, RAC audits resulted in reductions to revenue of approximately $6.8 million and $16.9 million, respectively.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our hospitals are reimbursed by differing types of private payors including HMOs, PPOs, other private insurance companies and employers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately $2,476.7 million, or 55.2% of total revenues for the year ended December 31, 2014. To attract additional volume, most of our hospitals offer discounts from established charges to certain large group purchasers of healthcare services. These discount programs often limit our ability to increase charges in response to increasing costs. Generally, patients covered by HMOs, PPOs and other private insurers will be responsible for certain co-payments and deductibles.

Self-pay and Charity Care

Self-pay revenues are derived from patients who do not have any form of healthcare coverage. Our revenues from self-pay patients were approximately $744.9 million, or 16.6% of total revenues for the year ended December 31, 2014. The revenues associated with self-pay patients are generally reported at our gross charges. We evaluate these patients, after the patient's medical condition is determined to be stable, for qualifications of Medicaid or other governmental assistance programs, as well as our local hospital's policy for charity care. We do not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is our policy not to pursue collection of amounts related to these patients.

A significant portion of self-pay patients are admitted through the emergency department and often require high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings. During the year ended December 31, 2014, our self-pay revenues decreased primarily as a result of a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who choose not to purchase insurance or who purchase insurance plans with high deductibles and high co-payments.

The following table lists our self-pay revenues and charity care write-offs for the years presented (in millions):

	Self-Pay Revenues	Charity Care Write-Offs	Combined Total
2014	$ 744.9	$ 80.9	$ 825.8
2013	$ 766.5	$ 132.1	$ 898.6
2012	$ 653.9	$ 112.5	$ 766.4

Provision for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Our provision for doubtful accounts had the effect of reducing total revenues by approximately $817.8 million, or 18.2% of total revenues for the year ended December 31, 2014. Prior to 2014, our provision for doubtful accounts as a percentage of revenue increased steadily year over year as a result of increases in our self-pay revenues. During the year ended December 31, 2014, our self-pay revenues decreased primarily as a result of a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. As a result, for the year ended December 31, 2014, our provision for doubtful accounts as a percentage of revenue also decreased.

We have an established process to determine the adequacy of the allowance for doubtful accounts that relies on a number of analytical tools and benchmarks to arrive at a reasonable allowance. No single statistic or measurement determines the adequacy of the allowance for doubtful accounts. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payor classification and revenue days in accounts receivable.

Health Care Reform

The Affordable Care Act dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Although some of the measures contained in the Affordable Care Act did not take effect until 2014 or do not take effect until later, certain of the reductions in Medicare spending, such as negative adjustments to the Medicare hospital inpatient and outpatient prospective payment system market basket updates and the incorporation of productivity adjustments to the Medicare program's annual inflation updates, became effective prior to 2014. During 2014, and primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. While we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict, will be gradual and may not offset scheduled decreases in reimbursement.

There have been and likely will continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the "individual mandate" provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of the Department of Health and Human Services ("HHS") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, at December 31, 2014, only eight of the states in which we operate are currently implementing expansions to their Medicaid programs. Accordingly, some low-income persons in other states that are not expanding Medicaid may not have insurance coverage as intended by the Affordable Care Act. In addition, the U.S. Supreme Court has agreed to hear a case known as King v. Burwell during 2015. This case challenges the extension of premium subsidies to individuals residing in the 37 states that have federally-run health insurance exchanges. If the U.S. Supreme Court decides that the Affordable Care Act does not authorize premium subsidies to federally-run health insurance exchange participants, premium subsidies for individuals purchasing their insurance through federally-run health insurance exchanges would become unavailable and would likely result in many of those individuals dropping their coverage and increasing the number of uninsured.

The Affordable Care Act changes how healthcare services are covered, delivered, and reimbursed. The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual implementation and possible amendment, as well as the uncertainty as to the extent to which states will choose to expand their Medicaid programs and the extent to which individuals will elect coverage. In addition, a number of the provisions of the Affordable Care Act that were scheduled to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, and the state-run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015 or 2016, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. As a result, we are unable to predict with any certainty the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. We are also unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions because many provisions will not be implemented for several years under the Affordable Care Act's implementation schedule. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act, and the results of such legislative efforts may impact our business in the future.

Expanded Coverage

Based on original Congressional Budget Office ("CBO") and CMS estimates, by 2019, the Affordable Care Act was expected to expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 94% of the legal U.S. population). This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. However, in July 2012, the CBO revised its estimate to reflect the impact of the U.S. Supreme Court's determination that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program was unconstitutional. On January 26, 2015, the CBO projected, as a result of the U.S. Supreme Court's decision and other factors, that there will be four million more uninsured individuals in 2015 and three million more uninsured individuals in 2022 than originally projected.

Medicaid Expansion

The primary public program coverage expansion will occur through changes in Medicaid, and to a lesser extent, expansion of the Children's Health Insurance Program ("CHIP"). The most significant changes will expand the categories of individuals eligible for Medicaid coverage and permit individuals with relatively higher incomes to qualify. The federal government reimburses the majority of a state's Medicaid expenses, and it conditions its payment on the state meeting certain requirements. The federal government currently requires that states provide coverage for only limited categories of low-income adults under 65 years old (e.g., women who are pregnant, and the blind or disabled). In addition, the income level required for individuals and families to qualify for Medicaid varies widely from state to state.

The Affordable Care Act materially changed the requirements for Medicaid eligibility. As originally enacted, commencing January 1, 2014, the Affordable Care Act essentially required all state Medicaid programs to provide Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the federal poverty level ("FPL"). In addition, the Affordable Care Act also required states to apply a "5% income disregard" to the Medicaid eligibility standard, so that Medicaid eligibility would effectively be extended to those with incomes up to 138% of the FPL. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "Enhanced FMAP") to cover the costs of covering the newly eligible individuals. Beginning in 2014, states began receiving an Enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Affordable Care Act. The Enhanced FMAP percentage is as follows: 100% for CYs 2014 through 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter. It is currently anticipated that the new eligibility requirements will expand Medicaid and CHIP coverage by an estimated 11 million individuals in 2015 and 16 million individuals in 2022, with a disproportionately large percentage of the new Medicaid coverage likely to be in states that currently have relatively low income eligibility requirements.

In 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, the expansion of the Medicaid program to all individuals under 65 years old with incomes at or under 133% of FPL is now optional. CMS has stated that there is no deadline for states to determine whether they will expand their Medicaid programs and has indicated that if a state does decide to expand its Medicaid program, it may also decide to drop the expanded coverage at a later date. While the CBO estimates that the U.S. Supreme Court's decision will likely result in the Medicaid and CHIP programs covering four million fewer individuals in 2022, it is unclear how many states will elect to implement the Medicaid expansion and when that expansion will occur. Therefore, we are unable to predict the future impact of the Medicaid expansion on our business model, financial condition or result of operations.

The Affordable Care Act also provides that the federal government will subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL. Approved state plans will be eligible to receive federal funding. The amount of that funding per individual will be equal to 95% of subsidies that would have been provided for that individual had he or she enrolled in a health plan offered through one of the health insurance exchanges (the "Exchanges"), as discussed below.

In addition, beginning in 2014, the Affordable Care Act allows Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program. However, states have significant flexibility in developing their state-specific presumptive eligibility rules and can establish standards that hospitals must meet in order to make presumptive eligibility determinations. For example, a state may impose standards related to the accuracy of a hospital's presumptive eligibility determinations, require hospitals to tell individuals how to apply for and obtain a full Medicaid application, establish policies that require hospitals to assist individuals in completing a Medicaid application, and develop proficiency standards, trainings, and audits with which hospitals must comply. If a presumptive eligibility determination is made in accordance with the applicable federal and state presumptive eligibility requirements, a state will not be permitted to recoup money from the hospital for the services that were rendered during the presumptive eligibility period. A state may, however, disqualify a hospital from making future presumptive eligibility determinations if the hospital does not meet the state's established performance standards.

Historically, states often have attempted to reduce Medicaid spending by limiting benefits and tightening Medicaid eligibility requirements. Effective March 23, 2010, the Affordable Care Act required states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. States with budget deficits may, however, seek exemptions from this requirement, but only to address eligibility standards that apply to adults making more than 133% of the FPL.

Private Sector Expansion

The expansion of health coverage through the private sector as a result of the Affordable Care Act will occur through new requirements on health insurers, employers and individuals. Commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, dropping coverage, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. Since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. In addition, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old.

Larger employers will be subject to new requirements and incentives to provide health insurance benefits to their full time employees. Effective January 1, 2015, employers with 100 or more employees that do not offer health insurance to 70% of their full-time employees and their dependents are subject to a penalty if an employee obtains coverage through one of the newly created Exchanges and the coverage is subsidized by the government. Effective January 1, 2016, that requirement will be extended to employers with 50 to 99 employees, and all employers subject to the requirement will be required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties. The employer penalties will range from $2,000 to $3,000 per employee, subject to certain thresholds and conditions.

As enacted, the Affordable Care Act uses various means to induce individuals who do not have health insurance to obtain coverage. As of January 1, 2014, individuals were required to maintain health insurance for a minimum defined set of benefits or pay a tax penalty; however, individuals technically had until March 31, 2014 to obtain insurance. The penalty in most cases is $95 in 2014, $325 in 2015, $695 in 2016, and indexed to a cost of living adjustment in subsequent years. The Internal Revenue Service ("IRS"), in consultation with HHS, is responsible for enforcing the tax penalty, although the Affordable Care Act limits the availability of certain IRS enforcement mechanisms. In addition, for individuals and families below 400% of the FPL, the cost of obtaining health insurance will be subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. It is anticipated that those at the lowest income levels will have the majority of their premiums subsidized by the federal government, in some cases in excess of 95% of the premium amount. To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. Based on CBO estimates, approximately 25 million individuals will obtain their health insurance coverage through an Exchange by 2019. The Affordable Care Act requires that the Exchanges be designed to make the process of evaluating, comparing and acquiring coverage simple for consumers. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits, and must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. Each level of plan must require the enrollee to share certain specified percentages of medical expenses up to the deductible/co-payment limit. Health insurers may establish varying deductible/co-payment levels, up to the statutory maximum (estimated to be between $6,000 and $7,000 for an individual). The health insurers must cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payors whose policies are listed on the Exchanges. We currently have contracts with Exchange payors in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payors.

Public Program Spending

The Affordable Care Act provides for Medicare, Medicaid and other federal healthcare program spending reductions between 2010 and 2019. The CBO previously estimated that these program spending reductions would include $156 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which would come from hospitals. CMS previously set this estimate at $233 billion. The CBO's estimate also included an additional $36 billion in reductions of Medicare and Medicaid DSH funding ($22 billion for Medicare and $14 billion for Medicaid). The CMS estimate included an additional $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare.

Payments for Hospitals

Under the Medicare program, hospitals receive reimbursement for general, acute care hospital inpatient services under the IPPS. CMS establishes fixed IPPS payment amounts per inpatient discharge based on the patient's assigned MS-DRG. These MS-DRG rates are updated each FFY, which begins October 1, using the hospital market basket index, which takes into account inflation experienced by hospitals and other entities outside the healthcare industry in purchasing goods and services.

The Affordable Care Act provides for a number of types of annual reductions in the market basket. One is a general reduction of a specified percentage each FFY starting in 2010 and extending through 2019. These reductions are as follows: FFY 2010, 0.25% for discharges occurring on or after April 1, 2010; 2011 (0.25%); 2012 (0.1%); 2013 (0.1%); 2014 (0.3%); 2015 (0.2%); 2016 (0.2%); 2017 (0.75%); 2018 (0.75%); and 2019 (0.75%).

Another type of reduction to the market basket is a "productivity adjustment" that was implemented by HHS beginning in FFY 2012. The amount of that reduction is the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS uses the Bureau of Labor Statistics ("BLS") 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Affordable Care Act does not contain guidelines for HHS to use in projecting the productivity figure. The market basket update for FFY 2015, FFY 2014 and FFY 2013 was reduced by 0.5%, 0.5% and 0.7%, respectively, as a result of this productivity adjustment.

Additional types of reductions include reductions in connection with Medicare's value-based purchasing program, Hospital-Acquired Condition (HAC) Reduction Program and Hospital Readmission Reduction Program, all of which are discussed in more detail below.

In addition to those reductions, there may be other upward or downward adjustments that CMS makes to the annual market basket update in any year, making it impracticable to predict in advance the overall impact on MS-DRG rates.

Quality-Based Payment Adjustments and Reductions for Inpatient Services

The Affordable Care Act established or expanded provisions to promote value-based purchasing and to link payments to quality and efficiency. Among other things, it requires HHS to implement a value-based purchasing program for inpatient hospital services. This program applied beginning in FFY 2013 to payments for discharges occurring on or after October 1, 2012, and rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1.0% in FFY 2013 and increasing by 0.25% for each fiscal year up to 2.0% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments beginning with inpatient discharges occurring on or after October 1, 2012. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

In addition, the Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. With respect to Medicare, beginning in FFY 2015, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1.0% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

Beginning in FFY 2013, inpatient payments were reduced if a hospital experiences "excessive readmissions" within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 1.0% for FFY 2012, 2.0% for FFY 2014, and 3.0% for FFY 2015 and beyond.

Outpatient Market Basket and Productivity Adjustment

Hospital outpatient services paid under OPPS are classified into APCs. The APC payment rates are updated each calendar year based on the market basket. The first two market basket changes outlined above — the general reduction and the productivity adjustment — apply to outpatient services as well as inpatient services, although these are applied on a calendar year basis. The percentage changes specified in the Affordable Care Act summarized above as the general reduction for inpatients — e.g., 0.2% in 2015 — are the same for outpatients.

Medicare and Medicaid Disproportionate Share Hospital Payments

The Medicare DSH program provides for additional payments to hospitals that treat a disproportionate share of low-income patients. Under the Affordable Care Act, beginning in FFY 2014, Medicare DSH payments were reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. In other words, the greater the level of coverage for the uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care.

In FFY 2015, the 75.0% portion of the Medicare DSH payment was reduced by 1.3% from FFY 2014 as a result of the change in the percentage of uninsured and the impact of hospitals that have undergone a merger.

The Affordable Care Act does not mandate what data source HHS must use to determine the reduction, if any, in the uninsured population nationally. In addition, with respect to defining "uncompensated care" for the purposes of the Medicare DSH reductions, the IPPS final rules for FFY 2014 and FFY 2015 provide that instead of actually measuring the amount of uncompensated care that is provided by DSH hospitals, CMS will use Medicaid days and Medicare Supplemental Security Income ("SSI") days as proxies for determining levels of uncompensated care. While difficult to predict, the use of Medicaid and Medicare SSI days to approximate levels of uncompensated care could have an adverse effect on DSH hospitals that are located in states that have opted to not expand their Medicaid programs.

In addition to Medicare DSH funding, hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. As originally enacted, the Affordable Care Act reduced funding for the Medicaid DSH hospital program in FFYs 2014 through 2020 by the following amounts: 2014 ($500 million); 2015 ($600 million); 2016 ($600 million); 2017 ($1.8 billion); 2018 ($5 billion); 2019 ($5.6 billion); and 2020 ($4 billion). In addition, the Middle Class Tax Relief and Job Creation Act of 2012 (the "Tax Relief Act") and the ATRA provide for additional Medicaid DSH reductions of $4.1 billion in FFY 2021 and $4.2 billion in FFY 2022, respectively. However, the Pathway Act repealed the Medicaid DSH reductions that were set to become effective in FFY 2014 and delayed the Medicaid DSH reductions that were set to become effective in FFY 2015 until FFY 2016. It also increased the Medicaid DSH reductions that were to become effective in FFY 2016 from $600 million to $1.2 billion and extended Medicaid DSH reductions through FFY 2023. PAMA further delays the Medicaid DSM reductions required by the Affordable Care Act that were scheduled to become effective in FFY 2016 to FFY 2017 and extends those reductions through FFY 2024. Under PAMA, the Medicaid DSH reductions will be $1.8 billion in FFY 2017, $4.7 billion in FFYs 2018 – 2020, $4.8 billion in FFY 2021, $5 billion in FFYs 2022 – 2023, and $4.4 billion in FFY 2024.

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The Medicare Shared Savings Program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. To date, approximately 420 ACOs have been established to participate in the Medicare program, and additional ACOs are being established by private payors.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation (the "Innovation Center") with responsibility for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. One initiative announced by the Innovation Center is a voluntary bundled payment initiative involving over 400 participants that links payments to participating providers for services provided during an episode of care. As required by the Affordable Care Act, HHS established a separate five-year, voluntary, national pilot program on payment bundling for Medicare services. Under the program, organizations enter into payment arrangements that include financial and performance accountability for episodes of care, and these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. Participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. The Affordable Care Act also provides for a bundled payment demonstration project for Medicaid services, but CMS has not yet implemented this project. HHS may select up to eight states to participate, and these state programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care.

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services. As of December 31, 2014, we operate one hospital through a joint venture with physicians in which we own a controlling interest.

Impact of Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. Further, the Affordable Care Act provides for a value-based purchasing program, which could create possible sources of additional revenue.

While the Affordable Care Act has had a positive impact on revenue, it is difficult to predict with great precision the timing or size of any potential revenue gains to us as a result of these elements of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act (the CBO made a number of assumptions to derive an estimate of 26 million, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance, the number of individuals who will obtain insurance through an Exchange and the number of states that will expand their Medicaid programs);
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the number of states that ultimately elect to expand their Medicaid programs and when that expansion occurs;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the future rates paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the Exchanges who select the high deductible plans and their ability to pay the deductibles;
- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied

to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and

- the possibility that implementation of provisions expanding health insurance coverage will be overturned, delayed or even blocked due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the new law.

On the other hand, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since 44.2% of our revenues in 2014 were from Medicare and Medicaid, collectively, reductions to these programs will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are fully implemented;
- whether reductions required by the Affordable Care Act will be changed by statute;
- the size of the Affordable Care Act's annual productivity adjustment to the market basket in future years;
- the amount of the Medicare DSH reductions that will be made, commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2017;
- what the losses in revenues will be, if any, from the Affordable Care Act's quality initiatives;
- how successful ACOs in which we participate, if any, will be at coordinating care and reducing costs;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

Because of the many variables involved, we are unable to predict the future effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Additionally, in light of the U.S. Supreme Court's ruling on the constitutionality of the Affordable Care Act, it is unclear how many states will ultimately implement the Medicaid expansion. Due to these factors, we are unable to predict with any reasonable certainty or otherwise quantify the future impact of the Affordable Care Act on our business model, financial condition or result of operations.

Competition for Patients

Our hospitals and other healthcare businesses operate in extremely competitive environments. Competition among healthcare providers occurs primarily at the local level. Accordingly, each facility develops its own strategies to address competition locally. A hospital's position within the geographic area in which it operates is affected by a number of competitive factors, including, but not limited to:

- the scope, breadth and quality of services a hospital offers to its patients and physicians;
- whether new, competitive services are subject to certificate of need or other restrictions;
- the number, quality and specialties of the physicians who admit and refer patients to the hospital;
- nurses and other healthcare professionals employed by the hospital or on the hospital's staff;
- the hospital's reputation;
- its managed care contracting relationships;

- its location and the location and number of competitive facilities and other healthcare alternatives;
- the physical condition of its buildings and improvements;
- the quality, age and state-of-the-art of its medical equipment;
- its parking or proximity to public transportation;
- the length of time it has been a part of the community;
- the relative convenience of the manner in which care is provided (for example, whether services are available on an outpatient basis and whether services can be obtained quickly);
- the choices made by the physicians on the medical staff of the hospital; and
- the charges for its services.

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

We also face increasing competition from specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers, as well as competing services rendered in physician offices. To the extent that other providers are successful in developing specialized outpatient facilities, our market share for those specialized services will likely decrease. Physician competition also has increased as physicians, in some cases, have become equity owners in surgery centers and outpatient diagnostic centers to which they refer patients. Some of our hospitals have developed specialized outpatient facilities where necessary to compete with these other providers.

Competition for Professionals

Our hospitals must also compete for professional talent. A significant factor in our future success will be the ability of our hospitals to attract and retain physicians, as it is physicians who decide whether a patient is admitted to the hospital and the procedures to be performed. We seek to attract physicians by striving to employ excellent nurses, equipping our hospitals with technologically advanced equipment and an attractive, up-to-date physical plant, properly maintaining the equipment and physical plant, and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our hospitals at any time, we believe that by striving to maintain and improve the quality of care at our hospitals and by maintaining ethical and professional standards, our hospitals will be better positioned to attract and retain qualified physicians with a variety of specialties.

We also recruit physicians to the communities in which our hospitals are located. The types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (Stark law), the Anti-kickback Statute, state anti-kickback statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred. In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician begins practicing in one of our communities.

Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities had more employed physicians at the end of 2014 than at the end of 2013. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

Employees

At December 31, 2014, we had approximately 38,000 employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our hospitals. Additionally, we employ a number of physicians. We are subject to federal minimum wage and hour laws and various state labor laws, and we maintain a number of different employee benefit plans. Approximately 1,200 of our employees are subject to collective bargaining agreements. We consider our employee relations to be generally good. Some of our hospitals experience union organizing activity from time to time; however, we do not currently expect any of these efforts to materially affect our future operations.

Government Regulation

Overview

All participants in the healthcare industry are required to comply with extensive government regulations at the federal, state and local levels. Under these laws and regulations, hospitals must meet requirements for licensure and to qualify to participate in government healthcare programs, including the Medicare and Medicaid programs. These requirements relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, rate-setting, compliance with building codes and environmental protection laws. If we fail to comply with applicable laws and regulations, we may be subject to criminal penalties and civil sanctions, and our hospitals may lose their licenses and ability to participate in Medicare and Medicaid. In addition, government regulations frequently change. When regulations change, we may be required to make changes in our facilities, equipment, personnel and services so that our hospitals remain licensed and qualified to participate in these programs. We believe that our hospitals are in substantial compliance with current federal, state and local regulations and standards.

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2014, with the exception of Bluegrass, Bell and Meyersdale, all of our hospitals were accredited by the Joint Commission.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. Quality improvement organizations may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider which is in substantial noncompliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Utilization review is also a requirement of most non-governmental managed care organizations.

Value-Based Purchasing

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events, reduces payments to hospitals that have high HAC rates and rewards hospitals that meet or exceed certain quality performance standards established by CMS. Many large commercial payers currently require hospitals to report quality data, and several commercial payers also do not reimburse hospitals for certain preventable adverse events.

In 2011, we were selected by HHS to participate in the Hospital Engagement Network as part of the nationwide Partnership for Patients Initiative designed to reduce injuries to patients in a hospital setting as well as minimize exposure to preventable illnesses through 2013. Subsequently, in 2013, we were selected to participate in a one year extension under the program. As part of our participation in the project, we received funding from HHS throughout 2014 to sponsor various types of training and education focused on patient safety and quality of care.

Fraud and Abuse Laws

Participation in Medicare and/or Medicaid programs is heavily regulated by federal statutes and regulations. If a hospital fails to comply substantially with the numerous federal laws governing the facility's activities, the hospital's participation in the Medicare and/or Medicaid programs may be terminated, and/or civil or criminal penalties may be imposed. For example, a hospital may lose its ability to participate in Medicare and/or Medicaid programs if it performs, among other things, any of the following acts:

- making claims to Medicare and/or Medicaid for services not provided or misrepresenting actual services provided in order to obtain higher payments;
- paying money to induce the referral of patients or purchase of items or services where such items or services are reimbursable under a federal or state healthcare program; or
- failing to provide appropriate emergency medical screening services to any individual who comes to a hospital's campus or otherwise failing to properly treat and transfer emergency patients.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal statutes that apply to all health plans regardless of whether any payments by such plans are made by or through a federal healthcare program. In addition, HIPAA created civil penalties for certain proscribed conduct, including upcoding and billing for medically unnecessary goods or services and established new enforcement mechanisms to combat fraud and abuse. These new mechanisms include a bounty system, where a portion of the payments recovered is returned to the applicable government agency, as well as a whistleblower program. HIPAA also expanded the categories of persons that may be excluded from participation in federal and state healthcare programs.

The Anti-kickback Statute prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by criminal and civil fines, exclusion from federal and state healthcare programs, imprisonment and damages up to three times the total dollar amount involved.

The Office of Inspector General ("OIG") of HHS is responsible for identifying fraud and abuse activities in government programs. In order to fulfill its duties, the OIG performs audits, investigations and inspections. In addition, it provides guidance to healthcare providers by identifying types of activities that could violate the Anti-kickback Statute. The OIG has identified the following hospital/physician incentive arrangements as potential violations:

- payment of any incentive by a hospital based on physician referrals of patients to the hospital;
- use of free or significantly discounted office space or equipment;
- provision of free or significantly discounted billing, nursing or other staff services;
- free training (other than compliance training) for a physician's office staff, including management and laboratory technique training;
- guarantees which provide that if a physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder;

- low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;
- payment of the costs for a physician's travel and expenses for conferences;
- payment of services which require few, if any, substantive duties by the physician or which are in excess of the fair market value of the services rendered; or
- purchasing goods or services from physicians at prices in excess of their fair market value.

We have a variety of financial relationships with physicians who refer patients to our hospitals, including employment contracts, leases, joint ventures, independent contractor agreements and professional service agreements. Physicians may also own shares of our common stock. We provide financial incentives to recruit physicians to relocate to communities served by our hospitals. These incentives for relocation include minimum revenue guarantees and, in some cases, loans. The OIG is authorized to publish regulations outlining activities and business relationships that would be deemed not to violate the Anti-kickback Statute. These regulations are known as "safe harbor" regulations. Failure to comply with the safe harbor regulations does not make conduct illegal, but instead the safe harbors delineate standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-kickback Statute. We intend for all our business arrangements to be in full compliance with the Anti-kickback Statute and seek to structure each of our arrangements with physicians to fit as closely as possible within an applicable safe harbor. However, not all of our business arrangements fit wholly within safe harbors, so we cannot guarantee that these arrangements will not be scrutinized by government authorities or, if scrutinized, that they will be determined to be in compliance with the Anti-kickback Statute or other applicable laws. If we violate the Anti-kickback Statute, we would be subject to criminal and civil penalties and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs.

The Stark law prohibits physicians from referring Medicare and Medicaid patients to selected types of healthcare entities in which they or any of their immediate family members have ownership or a compensation relationship unless an exception applies. These types of referrals are commonly known as "self referrals". A violation of the Stark law may result in a denial of payment and require refunds to patients and the Medicare program for all claims that were unlawfully submitted during the entire period that the violation existed, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for circumvention schemes, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information to HHS, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, violations of the Stark law could also result in penalties under the federal False Claims Act. There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception," which allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. One of our facilities is subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. Further, the Stark law and related regulations have been subject to little judicial interpretation to date. We anticipate that there will be further changes in the future that will require us to continue to modify our activities.

In addition to issuing new regulations, or applying new interpretations to existing rules or regulations, the federal government has modified its approach for ensuring compliance with and enforcing penalties for violations of the Stark law. In 2010, CMS also issued a "self-referral disclosure protocol" for hospitals and other providers that wish to self-disclose potential violations of the Stark law and attempt to resolve those potential violations and any related overpayment liabilities at levels below the maximum penalties and amounts set forth in the statute.

Federal False Claims Act

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government. The federal False Claims Act defines the term "knowingly" broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the "knowing" submission of a false or fraudulent claim for the purposes of the False Claims Act. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. When a private party brings a qui tam action under the federal False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. If a provider is found to be liable under the federal False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus mandatory civil monetary penalties of between $5,500 to $11,000 for each separate false claim. The government has used the federal False Claims Act to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality.

Changes in the Regulatory Environment

The Fraud Enforcement and Recovery Act of 2009 ("FERA") expanded the scope of the federal False Claims Act by, among other things, creating liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government and broadening protections for whistleblowers. In addition, the Affordable Care Act made several significant changes to healthcare fraud and abuse laws, including providing additional enforcement tools to the government, increasing cooperation between agencies by establishing mechanisms for the sharing of information and enhancing criminal and administrative penalties for non-compliance. For example, the Affordable Care Act (1) provides $350 million in increased federal funding over 10 years to fight healthcare fraud, waste and abuse; (2) expands the scope of the RAC program to include Medicaid; (3) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid payments to a provider of services or a supplier "pending an investigation of a credible allegation of fraud;" (4) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (5) requires providers to adopt compliance programs that meet certain specified requirements as a condition of their Medicare enrollment. The Affordable Care Act also expanded the scope of the False Claims Act to cover payments in connection with health insurance exchanges if those payments include any federal funds and provides that claims submitted in connection with patient referrals that result from violations of the Stark law or the Anti-kickback Statute constitute false claims for the purposes of the federal False Claims Act.

In addition to the changes mentioned above, the Affordable Care Act created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, and accurately prepare cost reports. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of health care providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law.

State Laws

Many of the states in which we operate have adopted laws similar to the Anti-kickback Statute and the Stark law. These state laws are generally very broad in scope and typically apply to patients whose treatment is covered by the Medicaid program and, in some cases, to all patients regardless of payment source. In addition, many of the states in which we operate have false claims statutes that impose civil and/or criminal liability for the types of acts prohibited by the federal False Claims Act or that otherwise prohibit the submission of false or fraudulent claims to the state government or Medicaid program. Violations of these laws are punishable by civil and/or criminal penalties and, in many cases, the loss of the facility's license. Although we believe that our operations and arrangements with physicians and other referral sources comply with the applicable state fraud and abuse laws, most of these laws have not been interpreted by any court or governmental agency, and there can be no assurance that the regulatory authorities responsible for enforcing these laws will determine that our arrangements comply with the applicable requirements.

Emergency Medical Treatment and Active Labor Act

All of our facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions or transfer exists regardless of a patient's ability to pay for treatment. Off-campus facilities such as specialty clinics, surgery centers and other facilities that lack emergency departments or otherwise do not treat emergency medical conditions are not generally subject to the EMTALA. They must, however, have policies in place that explain how the location should proceed in an emergency situation, such as transferring the patient to the closest hospital with an emergency department. There are severe penalties under the EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay, including civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. CMS has actively enforced the EMTALA and has indicated that it will continue to do so in the future. Although we believe that our hospitals comply with the EMTALA, we cannot predict whether CMS will implement new requirements in the future and, if so, whether our hospitals will comply with any new requirements.

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. In January 2009, CMS published its 10th revision of International Statistical Classification of Diseases and Related Health Problems ("ICD-10") and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the services provided in our hospitals and clinics will require much greater specificity. Implementation of ICD-10 will require a significant investment in technology and training. We may experience delays in reimbursement while our facilities and the payors from which we seek reimbursement make the transition to ICD-10. While HIPAA originally required implementation of ICD-10 to be achieved by October 1, 2013, CMS extended this deadline to October 1, 2014, and PAMA further delayed the effective date of the ICD-10 transition to October 1, 2015. If any of our hospitals fail to implement the new coding system by the deadline, the affected hospital will not be paid for services. We are not able to predict the overall financial impact of the Company's transition to ICD-10.

Additionally, we are subject to the privacy and security requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which are designed to protect the confidentiality, availability and integrity of health information. The HIPAA privacy and security regulations apply to health plans, health care clearinghouses, and healthcare providers that transmit health information in an electronic form in connection with HIPAA standard transactions. The HIPAA privacy standards, which apply to individually identifiable health information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally, impose extensive administrative requirements on us, require our compliance with rules governing the use and disclosure of this health information, and require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf. They also create rights for patients in their health information, such as the right to access and amend their health information and to request an accounting for certain disclosures of their health information. The HIPAA security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health information and to perform ongoing assessments of the potential risks and vulnerabilities to the confidentiality, integrity and availability of such information. Our facilities continue to remain subject to any state laws that are more restrictive than the privacy and security regulations issued under HIPAA. In addition, the Federal Trade Commission (the "FTC") has ruled that Section 5 of the Federal Trade Commission Act gives the FTC the authority to regulate as unfair business practices companies' inadequate data security programs that may expose consumers to fraud, identity theft and privacy intrusions, including the security programs of entities subject to HIPAA regulation. We believe that we are in material compliance with the privacy and security requirements of HIPAA and other applicable state and federal laws.

The HITECH Act, among other things, strengthened the HIPAA privacy and security regulations, significantly increased the penalties for violations of the HIPAA privacy and security regulations, created a private cause of action for state attorneys general for certain HIPAA violations, and extended many of HIPAA's privacy and security provisions to business associates. The HITECH Act also created a federal breach notification law that mirrors protections that many states have passed in recent years. This law requires us to notify affected individuals, and, in some cases, the Secretary of HHS and prominent local media outlets, of any unauthorized access, acquisition, or disclosure of an individual's unsecured protected health information that has been compromised. In 2011, HHS initiated a pilot audit program that ran through December 2012 in the first phase of HHS implementation of the HITECH Act's requirements of periodic audits of covered entities and business associates to ensure their compliance with the HIPAA privacy and security regulations and the breach notification requirements. In 2014, HHS announced its plan to survey about 800 organizations as the first step in selecting organizations for the next round of HIPAA audits, which are expected to occur in 2015. HHS officials have indicated that these audits will consist of a combination of remote desk audits and comprehensive onsite evaluations of covered entities and business associates and will focus on compliance with the HIPAA privacy, security and breach notification rules. HHS officials have also indicated that these audits could lead to compliance reviews or enforcement actions against organizations that fail to respond appropriately to audit requests or for which an audit reveals significant compliance issues. We cannot predict whether our hospitals will be selected for any future audit or the results of any such audit.

On January 17, 2013, HHS issued a final HIPAA omnibus rule (the "Final HIPAA Rule"), which became effective on March 26, 2013, that modified prior HIPAA regulations and implemented many of the provisions of the HITECH Act. Our facilities were required to comply with the applicable requirements of the Final HIPAA Rule beginning on September 23, 2013, except that certain agreements with business associates qualified for an extended compliance date of September 23, 2014. The Final HIPAA Rule modifications include, among other things: making our facilities' business associates directly liable for compliance with certain of the requirements of the HIPAA privacy and security regulations; making our facilities liable for the actions of their business associates if HHS determines an agency relationship exists between the facility and the business associate under federal agency law; requiring modifications to existing agreements with business associates; adding limitations on the use and disclosure of health information for marketing and fundraising purposes, and prohibiting the sale of health information without individual authorization; expanding our patients' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which our patient has paid out of pocket in full; requiring modifications to, and redistribution of, our facilities' notice of privacy practices; rules addressing enforcement of noncompliance with HIPAA due to willful neglect; an increased and tiered civil money penalty structure; and modifications to the breach notification rules that replace the "risk of harm" standard with a "low probability of compromise" standard, which would require our facilities to prepare a four factor risk assessment for impermissible uses and disclosures of unsecured protected health information. We cannot predict the financial impact to our facilities in implementing the provisions of the Final HIPAA Rule.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties. The HITECH Act and Final HIPAA Rule significantly increased the penalties for violations by introducing a tiered penalty system reflecting increasing levels of culpability, with penalties of up to $50,000 per violation with a maximum civil penalty of $1.5 million for violations of the same requirement in a calendar year. The HITECH Act and Final HIPAA Rule also extended the application of certain provisions of the security and privacy regulations to business associates and imposes direct civil and criminal liability on business associates for violation of the HIPAA regulations. The HITECH Act also authorizes state attorneys general to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to violations of HIPAA privacy and security regulations that affect their state residents. The applicable state laws regulating the privacy and security of patient health information could impose additional penalties. We expect increased enforcement of the requirements of HIPAA, the HITECH Act, and the Final HIPAA Rule by HHS and state attorneys general.

Corporate Practice of Medicine and Fee-Splitting

Some states have laws that prohibit unlicensed persons or business entities, including corporations or business organizations that own hospitals, from employing physicians. Some states also have adopted laws that prohibit direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We attempt to structure our arrangements with healthcare providers to comply with the relevant state laws and the few available regulatory interpretations.

Certificates of Need

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and expensive equipment at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of the new equipment or services and allow competing healthcare providers to challenge the need for the facility, service or equipment. We operate hospitals in twelve states that have adopted certificate of need laws — Alabama, Florida, Georgia, Kentucky, Louisiana, Michigan, Mississippi, Nevada, North Carolina, Tennessee, Virginia and West Virginia. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services at our facilities in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of hospital licenses. All other states in which we operate do not require a certificate of need prior to the initiation of new healthcare services. In these other states, our facilities are subject to competition from other providers who may choose to enter the market by developing new facilities or services.

Not-for-Profit Hospital Conversion Legislation

Many states have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In states that do not have such legislation, the attorneys general have demonstrated an interest in reviewing these transactions under their general obligations to protect charitable assets. These legislative and administrative efforts primarily focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the not-for-profit seller. Reviews and, in some instances, approval processes adopted by state authorities can add additional time to the closing of a not-for-profit hospital acquisition. Future actions by state legislators or attorneys general may seriously delay or even prevent our ability to acquire certain hospitals.

State Hospital Rate-Setting Activity

We currently operate two hospitals in West Virginia. The West Virginia Health Care Authority requires that requests for increases in hospital charges be submitted annually. Requests for rate increases are reviewed by the West Virginia Health Care Authority and are either approved at the amount requested, approved for lower amounts than requested, or are rejected. As a result, in West Virginia, our ability to increase our rates to compensate for increased costs per admission is limited, and the operating margins for our hospitals located in West Virginia may be adversely affected if we are not able to increase our rates as our expenses increase. We can provide no assurance that other states in which we operate hospitals will not enact similar rate-setting laws in the future.

Medical Malpractice Tort Law Reform

Medical malpractice tort law has historically been maintained at the state level. All states have laws governing medical liability lawsuits. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees. Recently, many states had bills introduced in their legislative sessions to address medical malpractice tort reform. Proposed solutions include enacting limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claims data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. Reform legislation has also been proposed, but not adopted, at the federal level that could preempt additional state legislation in this area.

Environmental Regulation

Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations, as well as our purchases and sales of healthcare facilities, are also subject to compliance with various other environmental laws, rules and regulations. Such compliance costs are not significant, and we do not anticipate that such compliance costs will be significant in the future.

Regulatory Compliance Program

It is our policy to conduct our business with integrity and in compliance with the law. We have in place and continue to enhance a company-wide compliance program that focuses on all areas of regulatory compliance including billing, reimbursement, cost reporting practices and contractual arrangements with referral sources.

This regulatory compliance program is intended to help ensure that high standards of conduct are maintained in the operation of our business and that policies and procedures are implemented so that employees act in full compliance with all applicable laws, regulations and company policies. Under the regulatory compliance program, every employee and certain contractors involved in patient care, coding and billing, receive initial and periodic legal compliance and ethics training. In addition, we regularly monitor our ongoing compliance efforts and develop and implement policies and procedures designed to foster compliance with the law. The program also includes a mechanism for employees to report, without fear of retaliation, any suspected legal or ethical violations to their supervisors, designated compliance officers in our hospitals, our compliance hotline or directly to our corporate compliance office. We believe our compliance program is consistent with standard industry practices.

The Audit and Compliance Committee of the Board of Directors oversees the Company's compliance efforts, and receives periodic reports from the Company's compliance and audit services groups, as well as guidelines, policies and processes for monitoring and mitigating risk relating to the financial statements and financial reporting processes, key credit risks, liquidity risks and market risks. The Company's Quality Committee also plays a significant role in evaluating clinical performance and industry practices.

Risk Management and Insurance

We retain a substantial portion of our professional and general liability risks through a self-insurance retention ("SIR") insurance program administered in-house by our risk department with assistance from our insurance brokers. At December 31, 2014, our SIR is $5.0 million with a $5.0 million inner aggregate per claim. Our SIR level is evaluated annually as a part of our insurance program's renewal process. We maintain professional and general liability insurance with unrelated commercial insurance carriers to provide for losses in excess of the SIR.

Our workers' compensation program has a $1.0 million deductible for each loss in all states except for Wyoming. Workers' compensation in Wyoming operates under a state specific program.

We also maintain directors' and officers', property and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through an unrelated commercial insurance company. We maintain large property insurance deductibles with respect to our facilities in coastal regions because of the high wind exposure and the related cost of such coverage. We have two locations that are considered a high exposure to named-storm risk and carry a deductible of 5% of their respective property values.

We operate a captive insurance company under the name Point of Life Indemnity, Ltd. This captive insurance company, which is licensed by the Cayman Islands Monetary Authority and is a wholly-owned subsidiary of LifePoint, issues malpractice insurance policies to our employed physicians in addition to providing workers' compensation deductible coverage.

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Item 1A. *Risk Factors.*

There are several factors, some beyond our control that could cause results to differ significantly from our expectations. Some of these factors are described below. Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this report (see, for example, Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*). Any factor described in this report could by itself, or together with one or more factors, adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations.

Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments or if managed care companies reduce reimbursement amounts. In addition, the financial condition of payors and healthcare cost containment initiatives may limit our revenues and profitability.

In 2014, we derived 44.2% of our revenues from the Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory changes, administrative rulings and determinations concerning patient and provider eligibility, the method of calculating reimbursements and requirements for utilization review. Furthermore, the Affordable Care Act, as amended by the Pathway Act and PAMA, the Tax Relief Act and the ATRA provide for material scheduled reductions in the growth of Medicare and Medicaid program spending, including reductions in market basket updates and DSH funding.

Medicaid programs, which are jointly funded by federal and state governments and are administered by states, provide healthcare benefits to qualifying individuals who are unable to afford care. A number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance such states' Medicaid systems.

In addition, revenues from HMOs, PPOs, insurance companies, employers and other private payors are the result of negotiated rates. These rates may decline based on renegotiations and the respective bargaining power of the parties. In addition, the general trend towards further consolidation among private payors should increase their bargaining power over fee structures. As a result, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. This includes moving away from a percent of charge payment structure to a fixed payment, which typically reduces our reimbursement rate and limits our ability to raise prices going forward. The impact of these changes is magnified by the fact that many individuals and employers have moved to private payor plans Low cost plans purchased through the healthcare exchanges are also increasingly using narrow and tiered networks that limit beneficiary provider choices, restrict or exclude our facilities or impose significantly higher cost sharing obligations when care is obtained from providers in a disfavored tier.

Efforts to impose greater discounts and more stringent cost controls by government and private payors will continue, thereby reducing the payments we receive for our services. As reimbursement from payors is reduced, if we are excluded from more payor networks or if the scope of services covered by payors is limited, there could be a material adverse effect on our revenues and results of operations.

We cannot predict with a great level of precision the effect that the Affordable Care Act and its ongoing implementation may have on our business, financial condition or results of operations.

The Affordable Care Act continues to alter the U.S. healthcare system by decreasing the number of uninsured Americans and through its attempts to reduce the overall cost of healthcare. The Affordable Care Act attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicare and Medicaid DSH payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. Certain of the reductions in Medicare spending, such as negative adjustments to the hospital inpatient and outpatient prospective payment system market basket updates and the revision of annual inflation updates have already become effective, but many of the other cost-containment measures, including planned payment reductions, are scheduled to take place over coming years.

During 2014, and primarily as a result of the expansion of state Medicaid programs, we experienced an increase in revenues from providing care to certain previously uninsured individuals. While we expect this trend to continue, the future impact and timing of such coverage expansion, and utilization of care by newly-insured individuals, remains difficult to predict and may not offset scheduled decreases in reimbursement. Only eight of the states in which we operate have decided to implement expansions to their Medicaid programs. Accordingly, some low-income persons in other states that are not expanding Medicaid will not have insurance coverage as intended by the Affordable Care Act.

The U.S. Supreme Court has also agreed to hear a case known as King v. Burwell during 2015. This case challenges the extension of premium subsidies to individuals residing in the 37 states that have federally-run health insurance exchanges. If the U.S. Supreme Court decides that the Affordable Care Act does not authorize premium subsidies to federally-run health insurance exchange participants, the decision would likely make it more difficult for uninsured individuals in those states to purchase coverage, upset the private insurance market and otherwise significantly affect implementation of the Affordable Care Act, in a manner that results in higher than projected numbers of uninsured individuals.

A number of the provisions of the Affordable Care Act that were scheduled to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, the state-run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015 or 2016. Additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. We are unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions because certain provisions are scheduled for implementation over the coming years. Furthermore, several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend all significant provisions of the Affordable Care Act. As a result of these factors and numerous other variables, including the law's complexity and the lack of complete implementing regulations and interpretive guidance, we are unable to predict with any certainty the future net effect of the Affordable Care Act on our business, financial condition or results of operations.

We conduct a significant portion of our operations through joint ventures, which may expose us to risks and uncertainties.

For financial or strategic reasons, we conduct much of our business through joint ventures. By far the largest of our joint ventures is Duke LifePoint Healthcare, which is owned by the Company and a wholly-controlled affiliate of Duke, and which currently operates twelve hospital campuses in four states. In recent years, most of our large acquisitions have been conducted through Duke LifePoint Healthcare.

While we own a substantial majority of the equity in Duke LifePoint Healthcare, the long term success of Duke LifePoint Healthcare is dependent on ongoing collaboration and the alignment of our interests with those of Duke. In the event of a material disagreement with Duke or the breach of our joint venture agreement, Duke LifePoint Healthcare may be subject to dissolution, unwinding or purchase of either party's interest, which could have a material adverse effect on our revenues and results of operations. Even if Duke LifePoint Healthcare is not dissolved or unwound, our inability to involve Duke LifePoint Healthcare in our acquisitions and future operations could make it more difficult to source new targets or win competitive bidding processes, and our revenue or earnings growth may be hindered.

We may encounter difficulty operating, integrating and improving financial performance at acquired hospitals. If we acquire hospitals with unknown or contingent liabilities, we could become liable for material obligations.

We may be unable to timely and effectively integrate hospitals that we acquire with our ongoing operations. Many of the hospitals we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired hospitals and we may experience such delays in implementing operating procedures and systems in newly or future acquired hospitals. Integrating an acquired hospital could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel.

We must integrate complex information, accounting and operational systems and internal controls over financial reporting of acquired hospitals into our existing systems and internal controls. While we devote a significant amount of employee and management resources on these integrations, we also rely heavily on third parties for systems integration. Our efforts to integrate new facilities, including causing those third parties to convert our newly acquired hospitals' systems, may fail or be significantly delayed. Failure to timely and effectively integrate or convert any of these systems could cause business interruption, affect physician and staff morale and our ability to accurately manage accounting, clinical, compliance and operational functions. As our acquisitions have become and may continue to become larger, any such failure could cause a material adverse effect on our results of operations.

Businesses we have acquired, or businesses we acquire in the future, may have unknown or contingent liabilities for past activities, including liabilities for failure to comply with laws and regulations, medical and general professional malpractice liabilities, worker's compensation or other employee-related liabilities, previous tax liabilities and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters, any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses. In addition, the actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and results of operations.

Medicaid supplemental payments ("MSPs") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. The two most prevalent forms of MSPs are DSH and Upper Payment Limit ("UPL") payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars.

MSP programs are jointly financed by state funds and federal matching funds. The state portion may be funded through general revenue, intergovernmental transfers from local governments or healthcare related taxes ("Provider Taxes") imposed by states in the form of a mandatory provider payment related to healthcare items or services.

Pursuant to the Affordable Care Act, as amended by the Pathway Act and PAMA, funding for Medicaid DSH programs is to be significantly reduced beginning in FFY 2017. Because most of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

UPL programs have expanded in recent years and related MSPs to our hospitals have similarly increased as states use UPL programs as a way to avoid or mitigate reimbursement cuts to providers. There are several factors that could adversely affect a state's UPL program and the UPL MSPs hospitals receive. In calculating a state's UPL, only services utilized by Medicaid beneficiaries paid on a fee-for-service basis may be counted. Services provided to Medicaid beneficiaries enrolled in managed care are not included in state UPL calculations, and as many states increase the use of managed care Medicaid programs UPL MSPs could be reduced. Some states that provide MSPs are reviewing these programs or have filed requests with CMS to replace these programs, which could result in MSPs being reduced or eliminated. In addition, state UPL funding, and matching federal funds, may be reduced if state or local governmental units are unable to (or simply decide not to) sustain historical funding levels or if Provider Taxes, which are currently subject to various federal regulations, are limited or eliminated by legislative or regulatory action.

We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in sanctions and even greater scrutiny that reduce our revenues and profitability.

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with physicians and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, OIG, the Department of Justice, state attorneys general, and contracted auditors, as well as private plaintiffs. Moreover, the Affordable Care Act created potential False Claims Act liabilities for failing to report and repay identified overpayments and return an overpayment within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later.

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. Recent enforcement actions have focused on financial arrangements between hospitals and physicians, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs, as described in the annual OIG Work Plan. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters. For a further discussion of these inquiries, proceedings and claims, see "Legal Proceedings" in Item 3 of this Report.

The laws and regulations with which we must comply are constantly in a state of change. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate our hospitals or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Finally, we are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. For example, our healthcare operations generate medical waste, such as pharmaceuticals, biological materials and disposable medical instruments that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Environmental regulations also may apply when we build new facilities or renovate existing hospitals, particularly older facilities. If we fail to comply with environmental regulations we may be liable for substantial investigation and clean-up costs or we may be subject to lawsuits by governmental authorities or private plaintiffs.

We may be subjected to actions brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the False Claims Act's "qui tam" or "whistleblower" provisions.

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false claims for payment to the federal government. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the federal False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus mandatory civil penalties ranging between $5,500 and $11,000 for each separate false claim.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. The government has used the False Claims Act to prosecute Medicare and other government healthcare program violations such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality. The Affordable Care Act also provides that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the federal False Claims Act, and some courts have held that a violation of the Stark law can result in False Claims Act liability, as well. In addition, a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.

Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many of these laws are broadly worded and may be interpreted or applied in ways that cannot be predicted. Therefore, we cannot assure you that our arrangements or business practices will be free from government scrutiny or be found to be in compliance with applicable fraud and abuse laws.

We may be subject to liabilities because of malpractice and related legal claims brought against our hospitals or healthcare providers associated with, or employed by, our hospitals or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.

We may be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our owned and leased hospitals and the activities of our employed or affiliated physicians. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our hospitals are found liable, any judgments against us may be material. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to the SIR, which for some periods has been as high as $10.0 million. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

Insurance coverage in the future may not continue to be available at a cost allowing us to maintain adequate levels of insurance with acceptable SIR level amounts. One or more of our insurance carriers may become insolvent and unable to fulfill its obligation to defend, pay or reimburse us when that obligation becomes due. In addition, physicians using our hospitals may be unable to obtain insurance on acceptable terms, which could result in these physicians not being able to meet the minimum insurance requirements in the applicable hospital medical staff bylaws or necessitate a reduction in the level of insurance required to be carried under such bylaws.

As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including enhanced medical necessity reviews for Medicare patients admitted as inpatients to general acute care hospitals for certain procedures (e.g., cardiovascular procedures) and audits of Medicare claims under the RAC programs. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, short stays, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

In addition, CMS announced in 2012 a three year demonstration project to allow RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. Under the demonstration project, RACs conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews focus on certain states (including six states in which we operate) with either high populations of fraud and error-prone providers or high claims volumes of short inpatient hospital stays.

The Affordable Care Act expanded the RAC program's scope to include managed Medicare and to include Medicaid claims, and all states are now required to establish programs to contract with RACs. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. In addition to RACs and MICs, the state Medicaid agencies and other contractors have also increased their review activities. Third party audits or investigations of Medicare or Medicaid claims could have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payors have instituted policies and procedures to substantially reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. Quality improvement organizations may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with quality standards be excluded from participation in the Medicare program. Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payors. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. In addition, CMS has issued the "two midnight rule," which revised its longstanding guidance to hospitals and physicians relating to when hospital inpatient admissions are deemed to be reasonable and necessary for payment under Medicare Part A and provides that, in addition to services that are designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally only appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (i) expects the beneficiary to require a stay that crosses at least two midnights and (ii) admits the beneficiary to the hospital based upon that expectation. CMS is prohibited from allowing recovery auditors to conduct inpatient hospital status reviews on claims with dates of admission October 1, 2013 through March 31, 2015, but, in the future, reviews could be conducted on claims with dates of admission after that time. Significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our revenues and results of operations.

We are subject to risks associated with outsourcing functions to third parties.

To improve operating margins, productivity and efficiency, we outsource selected nonclinical business functions to third parties. We take steps to monitor and regulate the performance of independent third parties to whom the Company delegates selected functions, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management and payroll services.

Arrangements with third party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, and we may not have effective recourse against the providers for those harms. The expanding role of third party providers may also require changes to our existing operations and the adoption of new procedures and processes for retaining and managing these providers, as well as redistributing responsibilities as needed, in order to realize the potential productivity and operational efficiencies. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating or transitioning arrangements with key vendors could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition phase.

Deterioration in the collectability of "patient due" accounts could adversely affect our revenues and results of operations.

The primary collection risks associated with our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. While we have experienced a reduction in uninsured patients, the risk of collection from insured patients, and the amounts due, have increased, and will likely continue to increase, as more individuals are enrolled in insurance plans with high deductibles or high co-payments, including those purchased on insurance exchanges.

The amount of our provision for doubtful accounts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. To date, the Affordable Care Act has decreased the number of uninsured individuals by incentivizing states to expand their Medicaid eligibility requirements, incentivizing employers to offer health insurance, and requiring individuals to carry health insurance or be subject to penalties. However, it is difficult to predict the future impact of the Affordable Care Act on the uninsured population and the collectability of patient receivables because of ongoing state determinations or whether to expand Medicaid, the availability of federal premium subsidies, as well as our inability to foresee how individuals, businesses, private payors and states will respond to the choices afforded them by the Affordable Care Act. If the recent decrease in the uninsured population does not continue, the proportion of accounts receivable being comprised of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and revenues. In addition, even after full implementation of the Affordable Care Act, we may continue to experience bad debts and be required to provide uninsured discounts and charity care for patients that choose not to purchase coverage, undocumented immigrants who are not permitted to enroll in a health insurance exchange or government healthcare programs and in states that do not expand their Medicaid programs.

The industry emphasis on value-based purchasing may negatively affect our revenues.

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payors currently require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

The Affordable Care Act contains a number of provisions intended to promote value-based purchasing. The Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Another provision reduces payments for all inpatient discharges for hospitals that experience excessive readmissions for certain conditions designated by HHS.

The Affordable Care Act also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1.00% in FFY 2013 and increasing by 0.25% each fiscal year up to 2.00% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. CMS recently announced its goal that 85% of Medicare fee-for-service payments be within value-based purchasing categories by 2016, and many large private payors have declared similar goals. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

We may have difficulty acquiring hospitals on favorable terms.

A significant element of our business strategy is expansion through the acquisition of acute care hospitals, especially those around which a system of hospitals and other healthcare services can be created. We face significant competition to acquire attractive hospitals, and we may not find suitable acquisitions on favorable terms. Our primary competitors for acquisitions have included for-profit and tax-exempt hospitals and hospital systems and privately capitalized start-up companies. Buyers with a strategic desire for any particular hospital — for example, a hospital located near existing hospitals or those who will realize economic synergies — have demonstrated an ability and willingness to pay premium prices for hospitals. Strategic buyers, as a result, can present a competitive barrier to our acquisition efforts.

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired hospital's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases. As part of our acquisition strategy, we often commit to making significant capital improvements at acquired facilities according to a defined schedule, as more fully discussed in Note 11 to our consolidated financial statements included elsewhere in this report. Such schedule may be difficult to achieve due to a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

Even if we are able to identify an attractive target, we may need to obtain financing for acquisitions, joint ventures or required capital improvements. Such financing may not be available, or we may incur or assume additional indebtedness as a result. Any financing arrangements we enter into may not be on terms favorable to us, and this could have a material adverse effect on our results of operations or stock price.

In recent years, the legislatures and attorneys general of several states have become more interested in sales of hospitals by tax-exempt entities. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions with tax-exempt organizations in the future. Our failure to acquire hospitals consistent with our growth plans could prevent us from increasing our revenues.

If we do not effectively attract, recruit and retain qualified physicians, our ability to deliver healthcare services efficiently will be adversely affected.

As a general matter, only physicians on our medical staffs may direct hospital admissions and the services ordered once a patient is admitted to a hospital. As a result, the success of our hospitals depends in part on the number and quality of the physicians on the medical staffs of our hospitals.

The success of our efforts to recruit and retain quality physicians depends on several factors, including the actual and perceived quality of services provided by our hospitals, our ability to meet demands for new technology, our ability to identify and communicate with physicians who want to practice in our communities. Our ability to attract and retain physicians is increasingly dependent on the ability of our hospitals to offer and sustain employment arrangements. In particular, we face intense competition in the recruitment and retention of specialists. We may not be able to recruit all of the physicians we target. In addition, we may incur increased malpractice, compliance or insurance expense if the quality of physicians we recruit does not meet our expectations.

Additionally, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred by them. All arrangements with physicians must also be fair market value and commercially reasonable.

In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician is practicing in one of our communities. For example, integrated accountable care organizations and other kinds of "narrow" provider networks or organizations may exclude our physicians from their plans' networks of healthcare providers. These contracting networks often organize hospitals, physicians and ancillary healthcare providers into exclusive networks involving a fewer number of healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

Generally, a small number of attending physicians within each of our facilities represent a large share of our inpatient revenues and admissions. The loss of one or more of these physicians — even if temporary — could cause a material reduction in our revenues, which could take significant time to replace given the difficulty and cost associated with recruiting and retaining physicians.

Factors related to our employment of physicians could affect our financial performance.

We have significantly increased the number of physicians we employ. We believe that physician employment by acute care hospitals is consistent with industry trends and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing costs to physicians, such as electronic health record ("EHR") implementation and professional liability insurance expenses. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, as well as require us to incur additional expenses. In recent years, physician reimbursements have been determined on a year by year basis, with future reimbursement cuts embedded into law. We cannot predict whether Congress will act to avert scheduled reimbursement cuts in any given year or otherwise address scheduled cuts on a long-term basis. If scheduled reimbursement reductions are not averted, the reimbursement received by us for services provided by our employed physicians, the physicians to whom our hospitals have provided recruitment assistance, and the physician members of our medical staffs would be adversely affected. The combination of reimbursement cuts, potential liabilities and increased expenses could have an adverse effect on our results of operations if current trends continue.

Our hospitals face competition for management and other non-physician staffing, which may increase labor costs and reduce profitability.

In addition to our physicians, the operations of our hospitals are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary or contract personnel. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

If access to our information systems is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. We rely on multiple third party providers of financial, clinical, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. We do not control the information systems of third party providers, and in some cases we may have difficulty accessing information archived on third party systems, which could subject us to liability for failure to respond to legal or payor information requests. If these systems fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for the urban healthcare market and not suited for our hospitals, our operations could suffer.

In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as HIPAA and EHR meaningful use regulations, may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for physicians, staff and, in some cases, patients. Some of our hospitals have recently converted or are currently converting from their existing system to another third party information system. If such conversions occurred on a large scale or if conversions at our larger facilities experience difficulties, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

If we fail to effectively and timely implement electronic health record and coding systems, our operations could be adversely affected.

As required by ARRA, the HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use EHR technology. HHS uses the Provider Enrollment, Chain and Ownership System ("PECOS") to verify Medicare enrollment prior to making EHR incentive program payments. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in FFY 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Even if we do meet such requirements, the incentive payments we have received in prior years for EHR implementation are scheduled to be materially reduced over the coming years and to end entirely in 2017. EHR incentive payments that we have previously recognized are subject to audit and potential recoupment if it is determined that we did not meet the applicable meaningful use standards required in connection with such incentive payments.

We are in the process of converting certain of our clinical and patient accounting information system applications to newer versions of existing applications or all together new applications at several of our facilities. In connection with our implementations and conversions, we have incurred significant capitalized costs and additional training and implementation expenses. System conversions to comply with EHR could be time consuming and disruptive for physicians and employees. Failure to implement EHR systems effectively and in a timely manner could have a material adverse effect on our results of operations.

Health plans and providers, including our hospitals, must transition to the new ICD-10 coding system, which greatly expands the number and detail of billing codes used for inpatient claims. Use of the ICD-10 system will be required on October 1, 2015. Transition to the new ICD-10 system requires significant investment in technology and the training of staff involved in the coding and billing process. Besides these upfront costs of transition to ICD-10, our hospitals might experience disruption or delays in payment due to technical or coding errors or other implementation issues involving our systems or the systems and implementation efforts of governmental payors, health plans and their business partners. Further, the transition to the more detailed ICD-10 coding system could cause decreased reimbursement if using ICD-10 codes result in conditions being reclassified to MS-DRGs or commercial payor or payment groupings with lower levels of reimbursement than assigned under the previous system.

We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees.

There are numerous federal and state laws and regulations addressing employee, patient and consumer privacy concerns, including unauthorized access to or theft of personal information. In the ordinary course of our business, we, and vendors acting on our behalf, collect and store sensitive data, including individual health data and other personally identifiable information of our patients and employees and such information is often targeted by criminal organizations. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy and information security laws. The HHS Office for Civil Rights has imposed civil monetary penalties and corrective action plans on covered entities for violating HIPAA's privacy and security rules. In addition, state attorneys general and private plaintiffs have brought civil actions seeking injunctions and damages in response to violations of HIPAA's privacy and security rules. If, in spite of our security and compliance efforts we or any of our business associates were to experience a breach, loss, or other compromise of such personal health information or other personally identifiable information, such event could disrupt our operations, result in increased data protection costs, damage our reputation, or result in regulatory penalties, legal claims and liability under HIPAA and other state and federal laws, which could have a material adverse effect on our results of operations.

Other hospitals and outpatient facilities provide services similar to those which we offer. In addition, physicians provide services in their offices that could be provided in our hospitals. These factors increase the level of competition we face and may therefore adversely affect our revenues and results of operations.

Competition among hospitals and other healthcare service providers, including outpatient facilities, has intensified in recent years. We compete with other hospitals, including larger tertiary care centers located in metropolitan areas. Although the hospitals with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local physicians to, or may be required by their health plan to travel to these hospitals. Furthermore, some of the hospitals with which we compete may offer more or different services than those available at our hospitals, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. Also, most of the hospitals that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals, in most instances, are also exempt from paying sales, property and income taxes.

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that hospitals submit in connection with their Medicare reimbursement. If the publicly-available performance data become a primary factor in where patients choose to receive care, and if competing hospitals have better results than our hospitals on those measures, our revenues and/or patient volumes could decline.

We also face significant and increasing competition from services offered by physicians (including physicians on our medical staffs) in their offices and from other specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers (including many in which physicians may have an ownership interest). Some of our hospitals have and will seek to develop outpatient facilities where necessary to compete effectively. However, to the extent that other providers are successful in developing outpatient facilities or physicians are able to offer additional, advanced services in their offices, our market share for these services will likely decrease in the future.

Many of the non-urban communities in which we operate continue to face challenging economic conditions and the closure of a small number of large employers in our markets can have a disproportionate impact on our hospitals.

While the U.S. economy as a whole is expanding, many of the non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment. The economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our hospitals primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to:

- defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals; or
- purchase a high-deductible insurance plan or no insurance at all, which increases a hospital's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

The occurrence of these events may impede our business strategies intended to generate organic growth and improve operating results at our hospitals.

Our revenues are especially concentrated in a small number of states which will make us particularly sensitive to regulatory and economic changes in those states.

Our revenues are particularly sensitive to regulatory and economic changes in states in which we generate the majority of our revenues including Virginia, Kentucky, Michigan, Tennessee, North Carolina, New Mexico, West Virginia and Arizona. The following table contains our revenues and revenues as a percentage of our total revenues by state for each of these states for the years presented (dollars in millions):

	Hospital Campuses in State as of December 31, 2014	Revenue Concentration by State					
		2014		2013		2012	
		Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Virginia	6	$ 624.4	13.9%	$ 469.2	12.8%	$ 413.6	12.2%
Kentucky	9	587.9	13.1	520.9	14.2	510.9	15.1
Michigan	3	460.8	10.3	345.4	9.4	103.9	3.1
Tennessee	10	404.5	9.0	394.9	10.7	375.3	11.1
North Carolina	7	372.6	8.3	129.6	3.5	137.6	4.1
New Mexico	2	266.5	5.9	256.5	7.0	299.6	8.8
West Virginia	2	246.9	5.5	245.9	6.7	266.2	7.8
Arizona	2	222.8	5.0	214.7	5.8	204.4	6.0

Accordingly, any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs, in the above-mentioned states or in Pennsylvania, where we anticipate Conemaugh will generate significant revenues, could have an adverse effect on our revenues or results of operations. Our concentration of revenues in these states also make it more likely that hurricanes, floods, persistent drought, power grid interruption or other factors beyond our control in these states could adversely affect our revenues or results of operations.

We have substantial indebtedness, and we may incur significant amounts of additional indebtedness in the future which could affect our ability to finance operations and capital expenditures, pursue desirable business opportunities or successfully operate our business in the future.

As of December 31, 2014, our total debt, excluding an unamortized discount and premium, was $2,208.6 million. We also have the ability to incur significant amounts of additional indebtedness, subject to the conditions imposed by the terms of the agreements and indentures governing our existing indebtedness or any additional indebtedness that we may incur in the future.

Although we believe that our future operating cash flow, together with available financing arrangements, will be sufficient to fund our operating requirements, our leverage and debt service obligations could have important consequences, including the following:

- Under our debt agreements, we are required to satisfy and maintain specified financial ratios and tests. Failure to comply with these obligations may cause an event of default which, if not cured or waived, could require us to repay substantial indebtedness immediately. Moreover, if debt repayment is accelerated, we will be subject to higher interest rates on our debt obligations as a result of these covenants, and our credit ratings may be adversely impacted.
- We may be vulnerable in the event of downturns and adverse changes in the general economy or our industry.
- We may have difficulty obtaining additional financing at favorable interest rates to meet our requirements for working capital, capital expenditures, acquisitions, general corporate or other purposes.
- We will be required to dedicate a substantial portion of our cash flow to the payment of principal and interest on indebtedness, which will reduce the amount of funds available for operations, capital expenditures and future acquisitions.
- Any borrowings we incur at variable interest rates generally expose us to increases in interest rates.
- A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. We may be required to pay our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in the debt agreements. It is not certain whether we will have, or will be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay such indebtedness and our other indebtedness.
- In the event of a default, we may be forced to pursue one or more alternative strategies, such as restructuring or refinancing our indebtedness, selling assets, reducing or delaying capital expenditures or seeking additional equity capital. There can be no assurances that any of these strategies could be effected on satisfactory terms, if at all, or that sufficient funds could be obtained to make these accelerated payments.

Covenant restrictions under certain of our debt agreements and indentures impose operating and financial restrictions on us and may limit our ability to operate our business and to make payments on the notes and other outstanding indebtedness.

Agreements governing our existing indebtedness contain covenants that restrict our ability to finance future operations or capital needs, to take advantage of other business opportunities that may be in our interest or to satisfy our other debt obligations. These covenants restrict our ability to, among other things:

- incur or guarantee additional debt or extend credit;
- pay dividends or make distributions on, or redeem or repurchase, our capital stock or certain other debt;
- make other restricted payments, including investments;
- dispose of assets;

- engage in transactions with affiliates;
- enter into agreements restricting our subsidiaries' ability to pay dividends;
- create liens on our assets or engage in sale/leaseback transactions;
- effect a consolidation or merger, or sell, transfer, lease all or substantially all of our assets; and
- repay our existing outstanding indebtedness.

Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. Twelve states in which we operate hospitals require a certificate of need for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and for certain other planned activities. We may not be able to obtain certificates of need required for expansion activities in the future. In addition, all of the states in which we operate facilities require hospitals and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

In the nine states in which we operate that do not require certificates of need for the purchase, construction and expansion of healthcare facilities or services, competing healthcare providers face low barriers to entry and expansion. If competing providers of healthcare services are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

Item 1B. ***Unresolved Staff Comments.***

We have no unresolved SEC staff comments.

Item 2. *Properties.*

The following table presents certain information with respect to our hospital campuses as of December 31, 2014:

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Alabama				
Andalusia Regional Hospital	Andalusia	May 11, 1999	88	Own
Lakeland Community Hospital[(a)]	Haleyville	December 1, 2002	59	Own
Northwest Medical Center[(a)]	Winfield	December 1, 2002	71	Lease
Russellville Hospital[(a)]	Russellville	October 3, 2002	100	Own
Vaughan Regional Medical Center[(b)]	Selma	April 15, 2005	175	Own [(b)]
Arizona				
Havasu Regional Medical Center[(c)]	Lake Havasu City	April 15, 2005	181	Own [(c)]
Valley View Medical Center	Fort Mohave	November 8, 2005	90	Own
Colorado				
Colorado Plains Medical Center	Fort Morgan	April 15, 2005	50	Lease
Florida				
Putnam Community Medical Center	Palatka	June 16, 2000	99	Own
Georgia				
Rockdale Medical Center	Conyers	February 1, 2009	158	Own
Indiana				
Scott Memorial Hospital[(d)]	Scottsburg	January 1, 2013	25	Own [(d)]
Kansas				
Western Plains Medical Complex	Dodge City	May 11, 1999	99	Own
Kentucky				
Bluegrass Community Hospital	Versailles	January 2, 2001	25	Own
Bourbon Community Hospital	Paris	May 11, 1999	58	Own
Clark Regional Medical Center	Winchester	May 1, 2010	79	Own
Georgetown Community Hospital	Georgetown	May 11, 1999	75	Own
Jackson Purchase Medical Center	Mayfield	May 11, 1999	107	Own
Lake Cumberland Regional Hospital	Somerset	May 11, 1999	295	Own
Logan Memorial Hospital	Russellville	May 11, 1999	75	Own
Meadowview Regional Medical Center	Maysville	May 11, 1999	100	Own
Spring View Hospital	Lebanon	October 1, 2003	75	Own
Louisiana				
Mercy Regional Medical Center – Acadian[(e)]	Eunice	April 15, 2005	42	Own
Mercy Regional Medical Center – Ville Platte[(e)]	Ville Platte	December 1, 2001	67	Own
Minden Medical Center	Minden	April 15, 2005	161	Own
Teche Regional Medical Center	Morgan City	April 15, 2005	165	Lease
Michigan				
Bell Hospital	Ishpeming	December 1, 2013	25	Own
Marquette General Hospital[(f)]	Marquette	September 1, 2012	307	Own [(f)]
Portage Health[(b)]	Hancock	December 1, 2013	96	Own [(b)]
Mississippi				
Bolivar Medical Center	Cleveland	April 15, 2005	200	Lease

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Nevada				
Northeastern Nevada Regional Hospital	Elko	April 15, 2005	75	Own
New Mexico				
Los Alamos Medical Center	Los Alamos	April 15, 2005	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	April 15, 2005	298	Lease
North Carolina				
Harris Regional Hospital(f)	Sylva	August 1, 2014	86	Own(f)
Haywood Regional Medical Center(f)	Clyde	August 1, 2014	169	Own(f)
Maria Parham Medical Center(g)	Henderson	November 1, 2011	102	Own(g)
Person Memorial Hospital(f)	Roxboro	October 1, 2011	110	Own(f)
Rutherford Regional Medical Center(g)	Rutherfordton	June 1, 2014	143	Own(g)
Swain County Hospital(f)	Bryson City	August 1, 2014	48	Own(f)
Wilson Medical Center(g)	Wilson	March 1, 2014	384	Own(g)
Pennsylvania				
Conemaugh Memorial Medical Center(f)	Johnstown	September 1, 2014	539	Own(f)
Meyersdale Medical Center(f)	Meyersdale	September 1, 2014	20	Own(f)
Miners Medical Center(f)	Hastings	September 1, 2014	30	Own(f)
Tennessee				
Crockett Hospital	Lawrenceburg	May 11, 1999	99	Own
Emerald-Hodgson Hospital	Sewanee	May 11, 1999	41	Own
Hillside Hospital	Pulaski	May 11, 1999	95	Own
Livingston Regional Hospital	Livingston	May 11, 1999	114	Own
Riverview Regional Medical Center	Carthage	September 1, 2010	35	Own
Southern Tennessee Medical Center	Winchester	May 11, 1999	157	Own
Starr Regional Medical Center – Athens(h)	Athens	October 1, 2001	118	Own
Starr Regional Medical Center – Etowah(h)	Etowah	July 1, 2012	160	Own
Sumner Regional Medical Center	Gallatin	September 1, 2010	155	Own
Trousdale Medical Center	Hartsville	September 1, 2010	25	Own
Texas				
Ennis Regional Medical Center	Ennis	April 15, 2005	60	Lease
Palestine Regional Medical Center	Palestine	April 15, 2005	156	Own
Parkview Regional Hospital	Mexia	April 15, 2005	58	Lease
Utah				
Ashley Regional Medical Center	Vernal	11-May-99	39	Own
Castleview Hospital	Price	11-May-99	49	Own
Virginia				
Clinch Valley Medical Center	Richlands	July 1, 2006	175	Own
Danville Regional Medical Center	Danville	July 1, 2005	250	Own
Fauquier Health(b)	Warrenton	November 1, 2013	210	Own(b)
Memorial Hospital of Martinsville and Henry County	Martinsville	April 15, 2005	220	Own
Twin County Regional Hospital(g)	Galax	April 1, 2012	141	Own(g)
Wythe County Community Hospital	Wytheville	June 1, 2005	100	Lease

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
West Virginia				
Logan Regional Medical Center	Logan	December 1, 2002	140	Own
Raleigh General Hospital	Beckley	July 1, 2006	300	Own
Wyoming				
SageWest Healthcare – Lander(i)	Lander	July 1, 2000	89	Own
SageWest Healthcare – Riverton(i)	Riverton	May 11, 1999	70	Own
			8,254	

(a) Effective January 1, 2015, we sold Lakeland, Northwest and Russellville.

(b) The hospital is owned and operated by a joint venture between us and a local not-for-profit entity. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.

(c) The hospital is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which the hospital is located is owned by the LifePoint member and leased to the joint venture.

(d) The hospital is owned and operated by RHN, a joint venture between us and Norton Healthcare, Inc. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.

(e) Mercy Regional Medical Center maintains a campus in both Acadian and Ville Platte.

(f) The hospital is owned and operated by Duke LifePoint Healthcare. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.

(g) The hospital is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.

(h) Starr Regional Medical Center maintains a campus in both Athens and Etowah.

(i) SageWest Healthcare maintains a campus in both Lander and Riverton.

We own and operate medical office buildings in conjunction with many of our hospitals. These medical office buildings are primarily occupied by physicians who practice at our hospitals. Additionally, we lease approximately 203,000 square feet of office space in Brentwood, Tennessee for our hospital support center. All of our facilities are suitable for their respective uses and are generally adequate for our present needs.

Item 3. ***Legal Proceedings.***

Hospitals are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages that may not be covered by insurance.

In addition, hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without our knowledge. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the OIG, the Department of Justice ("DOJ") and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from fiscal intermediaries, federal and state agencies. Any proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

The Affordable Care Act imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within 60 days of identification. Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law); and (3) self-disclosing to CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In connection with our acquisitions of Marquette General and Conemaugh, the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, we have agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's cash or cash equivalent indemnification threshold in accordance with the asset purchase agreement, we will likely be responsible for funding any deficit. We believe we have made reasonable estimates of our potential exposure for these two matters, and at December 31, 2014, we have recorded a reserve for Marquette General of $18.0 million.

On September 16, 2013, we and two of our hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the Southern District of West Virginia served a subpoena on Raleigh General Hospital. Raleigh General produced responsive documents to the subpoena, including patient files. The government investigations are ongoing and we continue to cooperate with the government in addressing these matters. Following reviews by independent interventional cardiologists, we notified patients of these two physicians who may have received an unnecessary procedure of such fact. Our efforts to locate and notify a relatively small number of these patients are ongoing.

We and/or Vaughan Regional Medical Center and several of our subsidiaries, as well as Dr. Seydi V. Aksut and certain parties unaffiliated with us, are named defendants in 13 individual lawsuits filed in December 2014, and two putative class action lawsuits, all filed in the Circuit Court of Dallas County, Alabama. These lawsuits allege that patients at Vaughan Regional Medical Center received improper interventional cardiology procedures. One of the putative class action lawsuits, filed on November 21, 2014, seeks certification of a class consisting of all Alabama citizens who underwent an invasive cardiology procedure at any LifePoint owned Alabama hospital and who received notice regarding the medical necessity of that procedure. The other putative class action lawsuit, filed on February 6, 2015, seeks certification of a class of individuals that underwent an interventional cardiology procedure that was not medically necessary and performed by Dr. Aksut. This action asserts, among other claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which, if successful, would result in the awarding of treble damages for any injury resulting from the RICO violation and attorneys' fees.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom we did not send notice, have been threatened and may be asserted against us or the hospital, and claims may also be asserted by patients at Raleigh General Hospital. Any present or future claims that are ultimately successful could result in us and/or the hospitals being found liable and the government investigations may also result in damages, fines and penalties. Such liability, damages and penalties could be material. We cannot, however, reasonably estimate the potential liability, if any, in connection with any of these matters, and no liability has been recorded as of December 31, 2014.

We do not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against us. Therefore, the final amounts paid to resolve the foregoing matters could be material and could materially differ from amounts currently recorded, if any. Any such changes in our estimates or any adverse judgments will impact our future results of operations and cash flows.

Item 4. *Mine Safety Disclosures.*

Not applicable.

PART II

Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.*

Market Information for Common Stock

Our common stock is listed on the NASDAQ Global Select Market under the symbol "LPNT." The high and low sales prices per share of our common stock were as follows for the periods presented:

	High	Low
2015		
First Quarter (through February 11, 2015)	$ 73.99	$ 64.52
2014		
First Quarter	$ 56.77	$ 50.18
Second Quarter	$ 66.02	$ 50.51
Third Quarter	$ 76.50	$ 60.04
Fourth Quarter	$ 74.76	$ 62.95
2013		
First Quarter	$ 48.79	$ 38.08
Second Quarter	$ 53.29	$ 43.13
Third Quarter	$ 52.61	$ 43.97
Fourth Quarter	$ 53.87	$ 46.64

On February 11, 2015, the last reported sales price for our common stock on the NASDAQ Global Select Market was $69.75 per share.

Stockholders

As of February 6, 2015, there were 9,523 holders of record of shares of our common stock.

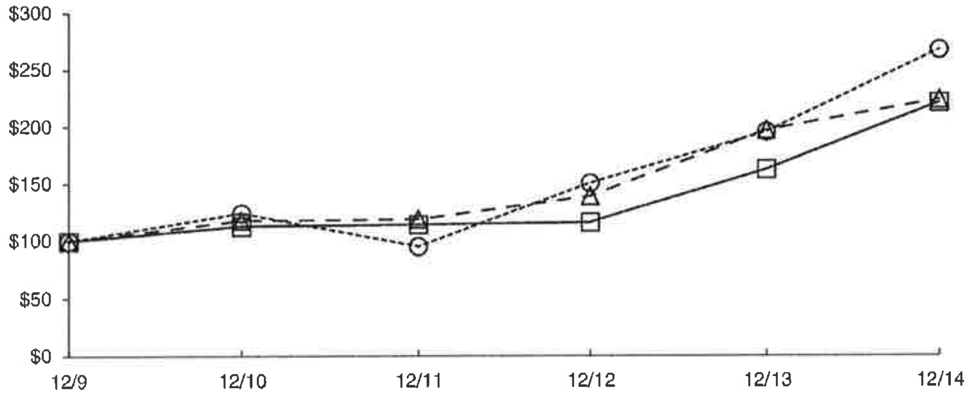
Dividends

We have never declared or paid cash dividends on our common stock. We intend to retain future earnings to finance the growth and development of our business and, accordingly, do not currently intend to declare or pay any cash dividends on our common stock. Our Board of Directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to declare or pay cash dividends. Delaware law prohibits us from paying any dividends unless we have capital surplus or net profits available for this purpose. In addition, the senior secured credit agreement with, among others, Citibank, N.A., as administrative agent, and the lenders party thereto (the "Senior Credit Agreement") and certain other indebtedness of the Company impose restrictions on our ability to pay dividends.

Stock Performance

The graph below compares the yearly percentage change of cumulative total stockholder return on our common stock with (a) the cumulative total return of a broad equity market index, the NASDAQ Composite Index (the "Broad Index") and (b) the cumulative total return of a published industry index, the S&P Health Care Facilities (Hospital Management) Index (the "Industry Index"). The graph begins on December 31, 2009, and the comparison assumes the investment of $100 on such date in each of our common stock, the Broad Index and the Industry Index and assumes the reinvestment of all dividends, if any. The table following the graph presents the corresponding data for December 31, 2009, and each subsequent fiscal year end.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN



	12/09	12/10	12/11	12/12	12/13	12/14
LifePoint Hospitals, Inc.	$ 100.00	$ 112.97	$ 114.20	$ 116.05	$ 162.43	$ 221.06
NASDAQ Composite	$ 100.00	$ 117.61	$ 118.70	$ 139.00	$ 196.83	$ 223.74
S&P Health Care Facilities	$ 100.00	$ 124.12	$ 95.18	$ 150.60	$ 195.36	$ 267.48

Recent Sales of Unregistered Securities

On September 1, 2014, as partial consideration in connection with our acquisition of Conemaugh Health System, we issued a warrant to Conemaugh Health System Inc. with rights to purchase 290,514 shares of our common stock at an exercise price of $74.15 per share. The warrant becomes exercisable ratably beginning one year from the date of issuance to three years after the date of issuance. The warrant expires ten years from the date of issuance. No underwriters were involved with the issuance of the warrant. The warrant was issued in reliance on an exemption from registration requirements of the Securities Act of 1933, as amended (the "Securities Act") afforded by Section 4(a)(2) of the Securities Act and Rule 506 of Regulation D thereunder, as a transaction not involving a public offering.

Recent Purchases of Equity Securities by the Issuer and Affiliated Purchasers

Our Board of Directors has authorized the repurchase of outstanding shares of our common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan") and a repurchase plan adopted in the first quarter of 2014 (the "2014 Repurchase Plan"). The 2011 Repurchase Plan provided for the repurchase of up to $350.0 million in shares of our common stock, and we have repurchased all shares authorized for repurchase under this plan. The 2014 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of our common stock through October 1, 2015, although we are not obligated to repurchase any specific number of shares. In connection with the 2014 Repurchase Plan, we repurchased approximately 0.7 million shares for an aggregate purchase price, including commissions, of $50.0 million at an average purchase price of $68.03 per share during the three months ended December 31, 2014. As of December 31, 2014, we had remaining authority to repurchase up to an additional $100.0 million in shares in accordance with the 2014 Repurchase Plan. We have designated the shares repurchased in accordance with our repurchase plans as treasury stock.

In connection with the 2014 Repurchase Plan, we have entered into a trading plan in accordance with SEC Rule 10b5-1 of the Exchange Act to facilitate repurchases of our common stock during our current black out period (the "10b5-1 Trading Plan"). The 10b5-1 Trading Plan became effective on December 17, 2014 and will expire on February 18, 2015.

We also redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder approved stock-based compensation plans. We redeemed a nominal number of shares vested under these plans during the three months ended December 31, 2014. We have designated these shares as treasury stock.

Our repurchase activity in accordance with our repurchase plans and the shares that we redeem from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder-approved stock-based compensation plans are more fully discussed in Note 8 to our consolidated financial statements included elsewhere in this report.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2014:

	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Program	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Program (In millions)
October 1, 2014 to October 31, 2014	—	$ —	—	$ 150.0
November 1, 2014 to November 30, 2014	684,036	$ 67.97	684,036	$ 103.5
December 1, 2014 to December 31, 2014[(a)]	51,572	$ 68.81	50,878	$ 100.0
Total	735,608	$ 68.03	734,914	$ 100.0

(a) Includes shares redeemed for tax withholding purposes upon vesting of certain previously granted stock awards under our various stockholder-approved stock-based compensation plans.

Equity Compensation Plan Information

Effective June 4, 2013, upon the approval of our stockholders, we replaced the Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and Amended and Restated Outside Directors Stock and Incentive Compensation Plan (the "ODSICP") with the 2013 Long-Term Incentive Plan (the "2013 LTIP"), a new combined plan covering all of our employees and non-employee directors. The 2013 LTIP provides for 3.6 million shares available for grant at a rate of 1.00 share for each stock option or appreciation rights award granted and 2.09 shares for each full-value award granted. No shares remain available for grant under the 1998 LTIP or the ODSICP.

The following table provides aggregate information as of December 31, 2014, with respect to shares of common stock that may be issued in accordance with our equity compensation plans:

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity Compensation Plans Approved by Security Holders	3,183,091(1)	$ 39.90(2)	1,953,267(3)
Equity Compensation Plans not Approved by Security Holders	None	None	None
Total	3,183,091	$ 39.90	1,953,267

(1) Includes the following:

- 779,884 shares of common stock to be issued upon exercise of outstanding stock options granted in accordance with the 2013 LTIP;
- 2,392,926 shares of common stock to be issued upon exercise of outstanding stock options granted in accordance with the 1998 LTIP; and
- 10,281 shares of common stock to be issued upon the vesting of deferred stock units outstanding in accordance with the ODSICP.

(2) Upon vesting, deferred stock units are settled for shares of common stock on a one-for-one basis. Accordingly, the deferred stock units have been excluded for purposes of computing the weighted-average exercise price.

(3) Includes the following:

- 1,926,441 shares of common stock available for issuance in accordance with the 2013 LTIP; and
- 26,826 shares of common stock available for issuance in accordance with the Amended and Restated Management Stock Purchase Plan (the "MSPP").

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Item 6. ***Selected Financial Data.***

The table below contains our selected financial data for, or as of the end of, the last five years ended December 31, 2014. The selected financial data is derived from our consolidated financial statements. The timing of acquisitions and divestitures completed during the years presented affects the comparability of the selected financial data. Additionally, we have recognized certain transaction and debt transaction costs during certain of the periods presented that affected the comparability of the selected financial data. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

	Years Ended December 31,				
	2014	2013	2012	2011	2010
	(In millions, except per share amounts)				
Statements of Operations Data:					
Revenues	$4,483.1	$3,678.3	$3,391.8	$3,026.1	$ 2,818.6
Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders	126.1	127.8	151.9	162.7	155.6
Income from continuing operations per share:					
Basic	$ 2.81	$ 2.76	$ 3.22	$ 3.30	$ 2.98
Diluted	$ 2.69	$ 2.68	$ 3.14	$ 3.22	$ 2.91
Weighted average shares outstanding:					
Basic	44.9	46.3	47.2	49.3	52.2
Diluted	46.9	47.6	48.4	50.5	53.5
Balance Sheet Data (as of end of year):					
Cash and cash equivalents	$ 191.5	$ 637.9	$ 85.0	$ 126.2	$ 207.4
Working capital	712.9	538.5	480.4	467.2	498.8
Property and equipment, net	2,377.5	2,197.2	2,030.9	1,830.4	1,668.6
Total assets	5,457.0	5,586.8	4,722.2	4,370.1	4,162.9
Total debt, excluding unamortized discounts and premium	2,208.6	2,386.3	1,739.3	1,652.8	1,651.7
Total LifePoint Hospitals, Inc. stockholders' equity	2,154.6	2,210.1	2,050.5	1,945.2	1,887.5

	Years Ended December 31,				
	2014	2013	2012	2011	2010
	(In millions, except per share amounts)				
Other Financial Data:					
Adjusted EBITDA[(a)]	$ 634.2	$ 537.0	$ 545.6	$ 536.2	$ 500.1
Capital expenditures	(207.1)	(185.2)	(221.4)	(219.9)	(168.7)
Cash provided by operating activities – continuing operations	412.3	354.1	382.9	401.2	375.7
Cash used in investing activities – continuing operations	(473.2)	(372.3)	(422.1)	(342.1)	(353.6)
Cash (used in) provided by financing activities – continuing operations	(385.5)	571.2	(1.3)	(140.6)	(0.3)

(a) We define Adjusted EBITDA as earnings before depreciation and amortization; interest expense, net; impairment charges; debt transaction costs; gain on settlement of pre-acquisition contingent obligation; provision for income taxes; (income) loss from discontinued operations, net of income taxes and net income attributable to noncontrolling interests and redeemable noncontrolling interests. We use Adjusted EBITDA to evaluate our operating performance and as a measure of performance for incentive compensation purposes. Additionally, our credit facility uses Adjusted EBITDA, subject to further permitted adjustments, for certain financial covenants. We believe Adjusted EBITDA is a measure of performance used by some investors, equity analysts and others to make informed investment decisions. In addition, multiples of current or projected Adjusted EBITDA are used to estimate current or prospective enterprise value. Adjusted EBITDA should not be considered as a measure of financial performance in accordance with U.S. generally accepted accounting principles ("GAAP"), and the items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net income, cash flows generated by operating, investing or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies.

The following table reconciles Adjusted EBITDA as presented above to net income attributable to LifePoint Hospitals, Inc. for the periods presented (in millions):

	Years Ended December 31,				
	2014	2013	2012	2011	2010
	(In millions, except per share amounts)				
Adjusted EBITDA	$ 634.2	$ 537.0	$ 545.6	$ 536.2	$ 500.1
Less:					
Depreciation and amortization	250.5	228.2	193.1	165.8	148.5
Interest expense, net	123.0	97.0	100.0	107.1	108.1
Impairment charges	57.7	—	4.0	—	—
Debt transaction costs	—	5.9	4.4	—	2.4
Gain on settlement of pre-acquisition contingent obligation	—	(5.6)	—	—	—
Provision for income taxes	68.1	79.3	88.5	97.8	82.4
(Income) loss from discontinued operations, net of income taxes	—	(0.4)	—	(0.2)	0.1
Net income attributable to noncontrolling interests and redeemable noncontrolling interests	8.8	4.4	3.7	2.8	3.1
Net income attributable to LifePoint Hospitals, Inc.	$ 126.1	$ 128.2	$ 151.9	$ 162.9	$ 155.5

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

We recommend that you read this discussion together with our consolidated financial statements and related notes included elsewhere in this report. Unless otherwise indicated, all relevant financial and statistical information included herein relates to our continuing operations.

We make forward-looking statements in this report, other reports and in statements we file with the SEC and/or release to the public. In addition, our senior management makes forward-looking statements orally to analysts, investors, the media and others. Broadly speaking, forward-looking statements include: projections of our revenues, net income, earnings per share, capital expenditures, cash flows, debt repayments, interest rates, operating statistics and data or other financial items; efforts to reduce the cost of providing healthcare while increasing quality; descriptions of plans or objectives of our management for future operations, services or growth plans including acquisitions, divestitures, business strategies, core strategies and other initiatives, including our relationship with Duke University Health System, Inc. through Duke LifePoint Healthcare; interpretations of Medicare and Medicaid laws and regulations and their effect on our business; and descriptions of assumptions underlying or relating to any of the foregoing.

In this report, for example, we make forward-looking statements, including statements discussing our expectations about: future financial performance and condition; future liquidity and capital resources; future cash flows; existing debt; changes in depreciation and amortization expenses; our business strategy and operating philosophy; effects of competition in a hospital's market; costs of providing care to our patients; our compliance with new and existing laws and regulations as well as costs and benefits associated with compliance; the impact of national healthcare reform; other income from electronic health records ("EHR"); anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to recent acquisitions and the expectation that capital commitments could be a significant component of future acquisitions; timeframes for completion of capital projects; implementation of supply chain management and revenue cycle functions; the impact of accounting methodologies; industry and general economic trends; patient shifts to lower cost healthcare plans which generally provide lower reimbursement; reimbursement changes, including policy considerations and changes resulting from state budgetary restrictions; the amount of reimbursement payments under the New Mexico state program; patient volumes and related revenues; claims and legal actions relating to professional liabilities; governmental investigations and voluntary self-disclosures; and physician recruiting and retention.

Forward-looking statements discuss matters that are not historical facts. Because they discuss future events or conditions, forward-looking statements often include words such as "can," "could," "may," "should," "believe," "will," "would," "expect," "project," "estimate," "seek," "anticipate," "intend," "target," "continue," "predict" or similar expressions. You should not unduly rely on forward-looking statements, which give our expectations about the future and are not guarantees. Forward-looking statements speak only as of the date they are made. We operate in a continually changing business environment, and new risk factors emerge from time to time. We cannot predict such new risk factors nor can we assess the impact, if any, of such new risk factors on our business or the extent to which any factor or combination of factors may cause actual results to differ materially from those expressed or implied by any forward-looking statement. We do not undertake any obligation to update our forward-looking statements to reflect events or circumstances after the date of this document or to reflect the occurrence of unanticipated events.

There are several factors, some beyond our control that could cause results to differ significantly from our expectations. Some of these factors are described in Part I, Item 1A. *Risk Factors*. Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this section and Part II, Item 7A. *Quantitative and Qualitative Disclosures about Market Risk*. Any factor described in this report could by itself, or together with one or more factors, adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations.

Overview

We operate general acute care hospitals primarily in non-urban communities in the U.S. At December 31, 2014, on a consolidated basis, we operated 67 hospital campuses in 21 states, having a total of 8,254 licensed beds. Effective January 1, 2015, we sold Lakeland, Northwest and Russellville. Upon completion of this sale, we operated 64 hospital campuses in 21 states, having a total of 8,024 licensed beds. We generate revenues primarily through hospital services offered at our facilities. We generated $4,483.1 million, $3,678.3 million and $3,391.8 million, respectively, in revenues during the years ended December 31, 2014, 2013 and 2012. In 2014, we derived 44.2% of our revenues from the Medicare and Medicaid programs, collectively. Payments made to our hospitals pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payors, together with certain limited services provided to Medicare recipients, to generate an operating profit. The hospital industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payors. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our hospitals.

Competitive and Structural Environment

The environment in which our hospitals operate is extremely competitive. In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our hospitals primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves.

Our hospitals face competition from other acute care hospitals, including larger tertiary hospitals located in larger markets and/or affiliated with universities; specialty hospitals that focus on one or a small number of very lucrative service lines but that are not required to operate emergency departments; stand-alone centers at which surgeries or diagnostic tests can be performed; and physicians on the medical staffs of our hospitals. In many cases, our competitors focus on the service lines that offer the highest margins. By doing so, our competitors can potentially draw the best-paying business out of our hospitals. This, in turn, can reduce the overall operating profit of our hospitals as we are often obligated to offer service lines that operate at a loss or that have much lower profit margins. We continue to see the shift of increasingly complex procedures from the inpatient to the outpatient setting and have also seen growth in the general shift of lower acuity procedures to physician offices and other non-hospital outpatient settings. These trends have, to some extent, offset our efforts to improve equivalent admission rates at many of our hospitals.

Our hospitals also face extreme competition in their efforts to recruit and retain physicians on their medical staffs. It is widely recognized that the U.S. has a shortage of physicians in certain practice areas, including primary care physicians and specialists such as cardiologists, oncologists, urologists and orthopedists, in various areas of the country. This fact, and our ability to overcome these shortages, is directly relevant to our growth strategies because cardiologists, oncologists, urologists and orthopedists are often the physicians in highest demand in communities where our hospitals are located. Larger tertiary medical centers are acquiring physician practices and employing physicians in some of our communities. While physicians in these practices may continue to be members of the medical staffs of our hospitals, they may be less likely to refer patients to our hospitals over time.

We believe other key factors in our competition for patients is the quality of our patient care and the perception of that quality in the communities where our hospitals are located, which may be influenced by, among other things, the technology, service lines and capital improvements made at our facilities and by the skills and experience of our non-physician employees involved in patient care.

Business Strategy

In order to achieve growth in patient volumes, revenues and profitability given the competitive and structural environment, we continue to focus our business strategy on the following:

- Measurement and improvement of quality of patient care and perceptions of such quality in communities where our hospitals are located;
- Targeted recruiting of primary care physicians and physicians in key specialties;
- Retention of physicians and efforts to improve physician satisfaction, including employing a greater number of primary care physicians as well as physicians in certain specialties;
- Retention and, where needed, recruitment of non-physician employees involved in patient care and efforts to improve employee satisfaction;
- Targeted investments in new technologies, new service lines and capital improvements at our facilities;
- Improvements in management of expenses and revenue cycle;
- Negotiation of improved reimbursement rates with non-governmental payors;
- Strategic growth through acquisition and integration of hospitals and other healthcare facilities where valuations are attractive and we can identify opportunities for improved financial performance through our management or ownership; and
- Developing strategic partnerships with not-for-profit healthcare providers to achieve growth in new regions.

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model of sharing centralized resources to support common business functions across multi-facility enterprises provides us efficiencies and is the most cost effective approach to managing these nonclinical business functions.

Regulatory Environment

Our business and our hospitals are highly regulated, and the penalties for noncompliance can be severe. We are required to comply with extensive, complicated and overlapping government laws and regulations at the federal, state and local levels. These laws and regulations govern every aspect of how our hospitals conduct their operations, from what service lines must be offered in order to be licensed as an acute care hospital, to whether our hospitals may employ physicians, and to how (and whether) our hospitals may receive payments pursuant to the Medicare and Medicaid programs. The failure to comply with these laws and regulations can result in severe penalties including criminal penalties, civil sanctions, and the loss of our ability to receive reimbursements through the Medicare and Medicaid programs.

Not only are our hospitals heavily regulated, but the rules, regulations and laws to which they are subject often change, with little or no notice, and are often interpreted and applied differently by various regulatory agencies with authority to enforce such requirements. Each change or conflicting interpretation may require our hospitals to make changes in their facilities, equipment, personnel or services, and may also require that standard operating policies and procedures be re-written and re-implemented. The cost of complying with such laws and regulations is a significant component of our overall expenses. Further, this expense has grown in recent periods because of new regulatory requirements and the severity of the penalties associated with non-compliance. Management anticipates that compliance expenses will continue to grow in the foreseeable future. The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting practices, cost reporting and billing practices, medical necessity, laboratory and home healthcare services, physician ownership of hospitals and other healthcare providers, and joint ventures involving hospitals and physicians. Hospitals continue to be one of the primary focal areas of the OIG, DOJ and other governmental fraud and abuse programs.

Health Care Reform

The Affordable Care Act changed how healthcare services are covered, delivered, and reimbursed. The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual implementation and possible amendment, as well as the uncertainty as to the extent to which states will choose to expand their Medicaid program and the extent to which individuals will elect coverage. In addition, a number of the provisions of the Affordable Care Act that were scheduled to become effective in 2014, such as the employer mandate, the Small Business Health Option Program, and the state-run exchange verification of income and Medicaid agency electronic notification of eligibility for tax credit and subsidy requirements, have been delayed until 2015 or 2016, and additional delays in the implementation of these or other provisions of the Affordable Care Act could be imposed in the future. As a result, we are unable to predict with any certainty the net effect on our business, financial condition or results of operations of the expected increases in insured individuals using our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions of the Affordable Care Act that may affect us. We are also unable to predict with a high level of precision how providers, payors, employers and other market participants will continue to respond to the various reform provisions because many provisions will not be implemented for several years under the Affordable Care Act's implementation schedule. Furthermore, the U.S. Supreme Court is reviewing whether premium subsidies may be made available to individuals residing in the 37 states that have federally-run health insurance exchanges, and several bills have been and may continue to be introduced in Congress to delay, defund or repeal implementation of or amend all significant provisions of the Affordable Care Act. The results of the U.S. Supreme Court's review and such legislative efforts may impact our business in the future.

Medicare and Medicaid Reimbursement

Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations. The Centers for Medicare and Medicaid Services ("CMS") has already begun to implement some of the Medicare reimbursement reductions required by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"). These revisions will likely be more frequent and significant as more of the Affordable Care Act's changes and cost-saving measures become effective. Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 require further reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposed a 2% reduction in Medicare spending effective as of April 1, 2013.

On February 2, 2015, the Office of Management and Budget released President Obama's proposed budget for federal fiscal year ("FFY") 2016 (the "Proposed Budget"). Among other things, the Proposed Budget would end sequestration but would also reduce Medicare spending by approximately $400 billion over the next 10 years. The Proposed Budget would achieve these reductions by, among other things, reducing Medicare coverage of bad debt, reducing payments to hospitals for graduate medical education programs, reducing payments to critical access hospitals, reducing payments to hospitals for services that are provided at off-campus hospital outpatient departments, and increasing financial liabilities for certain Medicare beneficiaries. We cannot predict whether the Proposed Budget will be implemented in whole or in part or whether Congress will take other legislative action to reduce spending on the Medicare and Medicaid programs. Additionally, future efforts to reduce the federal deficit may result in additional revisions to and payment reductions for the amounts we receive for our services.

Physician Services

Physician services are reimbursed under the Medicare physician fee schedule ("PFS") system, under which CMS has assigned a national relative value unit ("RVU") to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the sustainable growth rate ("SGR")) to arrive at the payment amount for each service.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula has resulted in payment decreases to physicians every year since 2002. However, all but one of those payment decreases has been averted by Congressional action. For CY 2014, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 20.1% to all physician payments under the PFS for CY 2014. The Pathway for SGR Reform Act of 2013, which was enacted on December 26, 2013 (the "Pathway Act") delayed the application of the SGR and provided for a 0.5% increase in PFS payment rates through March 31, 2014. PAMA extends the 0.5% increase in PFS payment rates established by the Pathway Act through December 31, 2014. It also provides that there will be no increase to the CY 2015 PFS from January 1, 2015 through March 31, 2015.

On November 13, 2014, CMS published the PFS final rule for CY 2015. In the final rule, CMS stated that application of the SGR to the PFS would result in a 21.2% reduction in payment rates for physicians' services beginning on April 1, 2015. We cannot predict whether Congress will pass legislation to avert the rate cut for the remainder of CY 2015 and/or otherwise adopt a permanent fix for the issues that are created by the application of the SGR. If the payment reduction to the PFS is not averted prior to March 31, 2015, the reimbursement received by our employed physicians, the physicians to whom our hospitals have provided recruitment assistance, and the physician members of our medical staffs would be adversely affected.

Adoption of Electronic Health Records

The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 ("ARRA"). The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments will be implemented in three stages. Stage 1 has been in effect since 2011; however, on September 4, 2012, HHS released final requirements for Stage 2, which took effect on October 1, 2013. We strive to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available incentive payments. Our compliance has and will continue to result in significant costs including business process changes, professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. As we complete our full implementation of certified EHR technology in accordance with all three phases of the program, our EHR incentive payments will decline and ultimately end. We currently estimate that at a minimum total costs incurred to comply will be recovered through the total EHR incentive payments over the projected lifecycle of this initiative.

An important component of the effective implementation of our EHR initiatives involves our uninterrupted access to reliable information systems. In late 2011, we entered into an agreement with a third party technology provider to design and operate a hosted data center for our critical third party information systems. In addition to providing a hosted data center, the third party technology provider offers help desk end-user support for certain clinical information systems, provides help desk and support functions for certain clinical information system applications, performs backups and recoveries of certain critical data, and monitors critical systems to facilitate the identifications of and rapid responses to certain system issues. We believe this agreement provides us with a single technology platform for the delivery of critical third party information systems for the majority of our hospitals and will improve the effectiveness and efficiency of key information support functions in a cost-effective and high quality manner.

Revenue Sources

Our hospitals generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including managed care organizations, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payor. Governmental payors generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payors. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Revenues from governmental payors, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a hospital is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels. These changes will likely become more frequent and significant as the provisions of the Affordable Care Act are implemented.

Revenues from health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payor with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. We expect this trend to continue in the coming years.

Self-pay revenues are primarily generated through the treatment of uninsured patients. During the year ended December 31, 2014, our self-pay revenues decreased primarily as a result of a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who choose not to purchase insurance or who purchase insurance plans with high deductibles and high co-payments. Additionally, certain of our hospitals participate in federal, state and local programs that provide for supplemental support and funding for the care of indigent patients and changes in these programs can impact our financial position and results of operations. For example, as a result of changes made to one such program in New Mexico, the Sole Community Provider Program ("New Mexico SCPP"), we recognized revenues of approximately $16.1 million, $16.3 million and $34.0 million during the years ended December 31, 2014, 2013 and 2012, respectively. Any changes to the New Mexico SCPP, for whatever reason, could have a material adverse effect on our financial position or results of operations in the period the changes occur.

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Our provision for doubtful accounts serves to reduce our reported revenues.

Results of Operations

The following definitions apply throughout the remaining portion of *Management's Discussion and Analysis of Financial Condition and Results of Operations*. Additionally, unless noted otherwise, discussions throughout the remaining portion of *Management's Discussion and Analysis of Financial Condition and Results of Operations* relate to the Company's continuing operations.

Admissions. Represents the total number of patients admitted to our hospitals and used by management and investors as a general measure of inpatient volume.

bps. Basis points.

Continuing operations. Continuing operations information includes the results of our hospital support center, our same-hospital operations and the results of our recent acquisitions completed in 2014 and 2013. Additionally, continuing operations information includes the results of River Parishes Hospital ("River Parishes"), which was sold effective November 1, 2014, and Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville"), which were sold effective January 1, 2015.

Effective tax rate. Provision for income taxes as a percentage of income from continuing operations before income taxes less net income attributable to noncontrolling interests.

Emergency room visits. Represents the total number of hospital-based emergency room visits.

Equivalent admissions. Management and investors use equivalent admissions as a general measure of combined inpatient and outpatient volume. We compute equivalent admissions by multiplying admissions (inpatient volume) by the outpatient factor (the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue). The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.

Medicare case mix index. Refers to the acuity or severity of illness of an average Medicare patient at our hospitals.

N/A. Not applicable.

Net revenue days outstanding. We compute net revenue days outstanding by dividing our accounts receivable net of allowance for doubtful accounts, by our revenue per day. Our revenue per day is calculated by dividing our quarterly healthcare services revenues by the number of calendar days in the quarter.

Outpatient surgeries. Outpatient surgeries are those surgeries that do not require admission to our hospitals.

Revenues. Revenues represent amounts recognized from all payors for the delivery of healthcare services, net of contractual discounts and the provision for doubtful accounts.

Same-hospital. Same-hospital information includes the results of our hospital support center and the same 53 hospitals operated during the years ended December, 31 2014 and 2013. Same-hospital information excludes the results of our recent acquisitions completed in 2014 and 2013, with the exception of Scott Memorial Hospital, which we acquired effective January 1, 2013 through our joint venture with Norton Healthcare, Inc. and which is included in our same-hospital information. Additionally, same-hospital information excludes our hospitals that have previously been disposed, in addition to Lakeland, Northwest and Russellville, which were sold effective January 1, 2015.

For the Three Months Ended December 31, 2014 and 2013

Operating Results Summary

The following table summarizes the results of operations for the three months ended December 31, 2014 and 2013 (dollars in millions):

	Three Months Ended December 31,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$1,483.7	117.5%	$1,159.9	121.8%
Provision for doubtful accounts	220.8	17.5	207.3	21.8
Revenues	1,262.9	100.0	952.6	100.0
Salaries and benefits	612.4	48.5	449.9	47.2
Supplies	199.0	15.8	147.7	15.5
Other operating expenses	299.9	23.7	233.9	24.6
Other income	(22.4)	(1.8)	(27.4)	(2.9)
Depreciation and amortization	59.7	4.8	59.1	6.2
Interest expense, net	29.2	2.3	26.5	2.8
Impairment charges	45.5	3.6	—	—
Debt transaction costs	—	—	1.2	0.1
	1,223.3	96.9	890.9	93.5
Income from continuing operations before income taxes	39.6	3.1	61.7	6.5
Provision for income taxes	12.9	1.0	23.8	2.5
Income from continuing operations	26.7	2.1	37.9	4.0
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(4.3)	(0.3)	(2.0)	(0.3)
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 22.4	1.8%	$ 35.9	3.7%

Revenues

The following table presents the components of revenues from continuing operations and on a same-hospital basis for the three months ended December 31, 2014 and 2013 (dollars in millions):

	Three Months Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2014	2013		
Continuing operations:				
Revenues before provision for doubtful accounts	$1,483.7	$1,159.9	$ 323.8	27.9%
Provision for doubtful accounts	220.8	207.3	13.5	6.5
Revenues	$1,262.9	$ 952.6	$ 310.3	32.6
Same-hospital:				
Revenues before provision for doubtful accounts	$1,124.3	$1,093.2	$ 31.1	2.8%
Provision for doubtful accounts	184.3	198.7	(14.4)	(7.3)
Revenues	$ 940.0	$ 894.5	$ 45.5	5.1

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the three months ended December 31, 2014 and 2013 (in millions):

	Three Months Ended December 31,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 357.9	28.3%	$ 295.9	31.1%
Medicaid	168.1	13.3	131.9	13.8
HMOs, PPOs and other private insurers	731.5	58.0	505.9	53.1
Self-pay	197.5	15.6	207.8	21.8
Other	28.7	2.3	18.4	2.0
Revenues before provision for doubtful accounts	1,483.7	117.5	1,159.9	121.8
Provision for doubtful accounts	(220.8)	(17.5)	(207.3)	(21.8)
Revenues	$1,262.9	100.0%	$ 952.6	100.0%

Our revenues per equivalent admission from continuing operations and on a same-hospital basis were as follows for the three months ended December 31, 2014 and 2013:

	Three Months Ended December 31,			
	2014	2013	Increase	% Increase
Revenues per equivalent admission – continuing operations	$ 8,226	$ 8,082	$ 144	1.8
Revenues per equivalent admission – same-hospital	$ 8,087	$ 8,081	$ 6	0.1

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts from continuing operations and on a same-hospital basis for the three months ended December 31, 2014 and 2013:

	Three Months Ended December 31,		Increase	% Increase
	2014	2013	(Decrease)	(Decrease)
Continuing operations:				
Admissions	60,252	49,112	11,140	22.7
Equivalent admissions	153,538	117,864	35,674	30.3
Medicare case mix index	1.38	1.38	—	—
Average length of stay (days)	4.9	4.6	0.3	6.5
Inpatient surgeries	16,012	13,133	2,879	21.9
Outpatient surgeries	59,775	47,901	11,874	24.8
Total surgeries	75,787	61,034	14,753	24.2
Emergency room visits	378,643	294,697	83,946	28.5
Outpatient factor	2.55	2.40	0.15	6.3
Same-hospital:				
Admissions	46,136	46,419	(283)	(0.6)
Equivalent admissions	116,230	110,696	5,534	5.0
Medicare case mix index	1.39	1.40	(0.01)	(0.7)
Average length of stay (days)	4.6	4.5	0.1	2.2
Inpatient surgeries	12,126	12,583	(457)	(3.6)
Outpatient surgeries	46,100	45,212	888	2.0
Total surgeries	58,226	57,795	431	0.7
Emergency room visits	298,905	275,562	23,343	8.5
Outpatient factor	2.52	2.38	0.14	5.7

For the three months ended December 31, 2014, our same-hospital revenues before provision for doubtful accounts increased $31.1 million, or 2.8%, to $1,124.3 million as compared to $1,093.2 million for the same period last year. This increase was primarily driven by increases in our same-hospital equivalent admissions as well as the favorable impact of healthcare reform. For the three months ended December 31, 2014, our same-hospital equivalent admissions increased 5.0% as compared to the same period last year, primarily as a result of an 8.5% increase in emergency room visits. Because the acuity for many of these additional emergency room visits was lower than the average acuity for the remaining equivalent admissions, the result was a lower revenue per equivalent admission. Additionally, we experienced a payor mix shift from self-pay payors to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. At December 31, 2014, only eight of the states in which we operate are currently implementing expansions to their Medicaid programs.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts from continuing operations and on a same-hospital basis for the three months ended December 31, 2014 and 2013 (dollars in millions):

	Three Months Ended December 31,					
	2014	% of Revenues	% of Revenues	2013	Decrease	% Decrease
Continuing operations:						
Related key indicators:						
Charity care write-offs	$ 14.6	1.2%	$ 26.7	2.8%	$ (12.1)	(45.5)%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 197.5	15.6%	$ 207.8	21.8%	$ (10.3)	(5.0)%
Net revenue days outstanding (at end of period)	56.4	N/A	59.1	N/A	(2.7)	(4.6)%
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 6.7	0.7%	$ 24.3	2.7%	$ (17.6)	(72.4)%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 159.4	17.0%	$ 198.9	22.2%	$ (39.5)	(19.9)%
Net revenue days outstanding (at end of period)	57.2	N/A	59.2	N/A	(2.0)	(3.4)%

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the three months ended December 31, 2014, our provision for doubtful accounts increased by $13.5 million, or 6.5%, to $220.8 million on a continuing operations basis and decreased by $14.4 million, or 7.3%, to $184.3 million on a same-hospital basis as compared to the same period last year. Same-hospital self-pay revenues decreased by $39.5 million over the same period last year. The decrease in same-hospital self-pay revenues is primarily due to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. However, as patient financial responsibility has continued to increase with higher co-payment and deductible obligations, our provision for doubtful accounts has increased to reflect the difficulty in collecting these amounts. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Critical Accounting Estimates."

Our net revenue days outstanding at December 31, 2014 improved to 56.4 days compared to 59.1 days at December 31, 2013 on a continuing operations basis. On a same-hospital basis, our net revenue days outstanding at December 31, 2014 improved to 57.2 days compared to 59.2 days at December 31, 2013.

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the three months ended December 31, 2014 and 2013:

	Three Months Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 612.4	48.5%	$ 449.9	47.2%	$ 162.5	36.1%
Man-hours per equivalent admission	109	N/A	109	N/A	—	—%
Salaries and benefits per equivalent admission	$ 4,036	N/A	$ 3,793	N/A	$ 243	6.4%

For the three months ended December 31, 2014, our salaries and benefits expense increased to $612.4 million, or 36.1%, as compared to $449.9 million for the same period last year primarily as a result of our recent acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the three months ended December 31, 2014 and 2013:

	Three Months Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 199.0	15.8%	$ 147.7	15.5%	$ 51.3	34.8%
Supplies per equivalent admission	$ 1,295	N/A	$ 1,254	N/A	$ 41	3.3%

For the three months ended December 31, 2014, our supplies expense increased to $199.0 million, or 34.8%, as compared to $147.7 million for the same period last year primarily as a result of our recent acquisitions.

Other Operating Expenses

The following table summarizes our other operating expenses for the three months ended December 31, 2014 and 2013 (dollars in millions):

	Three Months Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 45.0	3.6%	$ 40.2	4.2%	$ 4.8	11.7%
Utilities	22.9	1.8	17.7	1.8	5.2	30.2
Repairs and maintenance	35.1	2.8	25.6	2.7	9.5	36.9
Rents and leases	14.0	1.1	7.7	0.8	6.3	81.2
Insurance	13.6	1.1	11.3	1.2	2.3	19.8
Physician recruiting	4.9	0.4	6.0	0.6	(1.1)	(17.5)
Contract services	88.1	7.0	64.6	6.8	23.5	36.5
Non-income taxes	34.3	2.7	26.6	2.8	7.7	29.0
Other	42.0	3.2	34.2	3.7	7.8	23.0
	$ 299.9	23.7	$ 233.9	24.6	$ 66.0	28.3%

For the three months ended December 31, 2014, our other operating expenses increased to $299.9 million, or 28.3%, as compared to $233.9 million for the same period last year primarily as a result of our recent acquisitions. In addition to our recent acquisitions, our other operating expenses increased primarily as a result of an increase in contract services due to increased fees and expenses related to the completion of our shared centralized resource initiatives at the majority of our hospitals.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with Accounting Standards Codification ("ASC") 450-30, "Gain Contingencies" ("ASC 450-30") when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the three months ended December 31, 2014, we recognized $22.4 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $27.4 million recognized in the same period last year.

Depreciation and Amortization

For the three months ended December 31, 2014, our depreciation and amortization expense increased by $0.6 million, or 1.0% to $59.7 million, or 4.8% of revenues, as compared to $59.1 million, or 6.2% of revenues for the same period last year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. These increases were partially offset by decreases resulting from the finalization of the purchase price allocations for certain of our recent acquisitions. Furthermore, many of our recent acquisitions' depreciation and amortization expense as a percentage of revenue is lower than the Company's historical rates. We anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense

For the three months ended December 31, 2014, our interest expense increased by $2.7 million, or 9.9% to $29.2 million as compared to $26.5 million for the same period last year. The increase in our interest expense is primarily attributable to an increase in our total debt outstanding during the three months ended December 31, 2014 as compared to the same period last year. On December 6, 2013, we issued in a private placement $700.0 million of 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") with The Bank of New York Mellon Trust Company, N.A., as trustee. The net proceeds from this issuance were partially used to repay $100.0 million of our senior secured incremental term loans (the "Incremental Term Loans"). Subsequently, on May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes with terms substantially identical to those of the initial offering. The additional notes were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of our outstanding 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes"). Including the impact of the premium, the additional 5.5% Senior Notes were issued at an effective rate of 4.9%. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charges

In connection with our entry into a definitive agreement to sell almost all of the assets of Lakeland, Northwest and Russellville, we recognized impairment charges in the aggregate of $45.5 million, $28.1 million net of income taxes, or $0.60 loss per diluted share, during the three months ended December 31, 2014. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

Provision for Income Taxes

Our provision for income taxes was $12.9 million, or 1.0% of revenues, for the three months ended December 31, 2014, as compared to $23.8 million, or 2.5% of revenues, for the same period last year. The effective tax rate decreased to 36.6% for the three months ended December 31, 2014, compared to 39.9% for the same period last year. Our effective tax rate was lower for the three months ended December 31, 2014 primarily due to the reversal of accrued interest as a result of the favorable resolution of a previously open tax matter following the conclusion of an IRS examination. Our effective tax rate was higher for the three months ended December 31, 2013 primarily as a result of the recognition of a $6.0 million valuation allowance against our deferred tax assets for Federal net operating losses generated by our Michigan physician practice operations for which we did not believe we would be able to offset against future operational income.

For the Years Ended December 31, 2014 and 2013

Operating Results Summary

The following table summarizes the results of operations for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 5,300.9	118.2%	$ 4,428.7	120.4%
Provision for doubtful accounts	817.8	18.2	750.4	20.4
Revenues	4,483.1	100.0	3,678.3	100.0
Salaries and benefits	2,134.5	47.6	1,727.4	47.0
Supplies	699.0	15.6	577.1	15.7
Other operating expenses	1,087.3	24.3	900.9	24.4
Other income	(71.9)	(1.6)	(64.1)	(1.7)
Depreciation and amortization	250.5	5.6	228.2	6.2
Interest expense, net	123.0	2.7	97.0	2.6
Impairment charges	57.7	1.3	—	—
Debt transaction costs	—	—	5.9	0.2
Gain on settlement of pre-acquisition contingent obligation	—	—	(5.6)	(0.2)
	4,280.1	95.5	3,466.8	94.2
Income from continuing operations before income taxes	203.0	4.5	211.5	5.8
Provision for income taxes	68.1	1.5	79.3	2.2
Income from continuing operations	134.9	3.0	132.2	3.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.8)	(0.2)	(4.4)	(0.1)
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 126.1	2.8%	$ 127.8	3.5%

Revenues

The following table presents the components of revenues from continuing operations and on a same-hospital basis for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2014	2013		
Continuing operations:				
Revenues before provision for doubtful accounts	$ 5,300.9	$ 4,428.7	$ 872.2	19.7%
Provision for doubtful accounts	817.8	750.4	67.4	9.0
Revenues	$ 4,483.1	$ 3,678.3	$ 804.8	21.9
Same-hospital:				
Revenues before provision for doubtful accounts	$ 4,414.2	$ 4,274.0	$ 140.2	3.3%
Provision for doubtful accounts	709.7	720.6	(10.9)	(1.5)
Revenues	$ 3,704.5	$ 3,553.4	$ 151.1	4.3

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2014 and 2013 (in millions):

	Years Ended December 31,			
	2014		2013	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 1,361.4	30.4%	$ 1,199.5	32.6%
Medicaid	619.8	13.8	517.0	14.1
HMOs, PPOs and other private insurers	2,476.7	55.2	1,876.1	51.0
Self-pay	744.9	16.6	766.5	20.8
Other	98.1	2.2	69.6	1.9
Revenues before provision for doubtful accounts	5,300.9	118.2	4,428.7	120.4
Provision for doubtful accounts	(817.8)	(18.2)	(750.4)	(20.4)
Revenues	$ 4,483.1	100.0%	$ 3,678.3	100.0%

Our revenues per equivalent admission from continuing operations and on a same-hospital basis were as follows for the years ended December 31, 2014 and 2013:

	Years Ended December 31,			
	2014	2013	Increase	% Increase
Revenues per equivalent admission – continuing operations	$ 8,145	$ 7,852	$ 293	3.7
Revenues per equivalent admission – same-hospital	$ 8,053	$ 7,932	$ 121	1.5

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts from continuing operations and on a same-hospital basis for the years ended December 31, 2014 and 2013:

	Years Ended December 31,		Increase (Decrease)	% Increase (Decrease)
	2014	2013		
Continuing operations:				
Admissions	221,587	199,252	22,335	11.2
Equivalent admissions	550,422	468,441	81,981	17.5
Medicare case mix index	1.38	1.37	0.01	0.7
Average length of stay (days)	4.9	4.6	0.3	6.5
Inpatient surgeries	59,231	53,306	5,925	11.1
Outpatient surgeries	214,130	183,311	30,819	16.8
Total surgeries	273,361	236,617	36,744	15.5
Emergency room visits	1,363,459	1,171,537	191,922	16.4
Outpatient factor	2.48	2.35	0.13	5.7
Same-hospital:				
Admissions	187,373	191,364	(3,991)	(2.1)
Equivalent admissions	460,001	447,983	12,018	2.7
Medicare case mix index	1.39	1.38	0.01	0.7
Average length of stay (days)	4.6	4.6	—	—
Inpatient surgeries	50,228	51,776	(1,548)	(3.0)
Outpatient surgeries	181,719	176,872	4,847	2.7
Total surgeries	231,947	228,648	3,299	1.4
Emergency room visits	1,153,363	1,116,797	36,566	3.3
Outpatient factor	2.46	2.34	0.12	4.9

For the year ended December 31, 2014, our same-hospital revenues before provision for doubtful accounts increased $140.2 million, or 3.3%, to $4,414.2 million as compared to $4,274.0 million for the prior year. This increase was primarily driven by increases in our same-hospital equivalent admissions, higher contracted rates from HMOs, PPOs and other private insurers as well as the favorable impact of healthcare reform. For the year ended December 31, 2014, our same-hospital equivalent admissions increased 2.7% as compared to the prior year, primarily as a result of a 1.4% increase in total surgeries and a 3.3% increase in emergency room visits. Additionally, we experienced a payor mix shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. At December 31, 2014, only eight of the states in which we operate are currently implementing expansions to their Medicaid programs.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts from continuing operations and on a same-hospital basis for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Decrease	% Decrease
Continuing operations:						
Related key indicators:						
Charity care write-offs	$ 80.9	1.8%	$ 132.1	3.6%	$ (51.2)	(38.8)%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 744.9	16.6%	$ 766.5	20.8%	$ (21.6)	(2.8)%
Net revenue days outstanding (at end of period)	56.4	N/A	59.1	N/A	(2.7)	(4.6)%
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 60.4	1.6%	$ 129.0	3.6%	$ (68.6)	(53.2)%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 630.0	17.0%	$ 736.8	20.7%	$(106.8)	(14.5)%
Net revenue days outstanding (at end of period)	57.2	N/A	59.2	N/A	(2.0)	(3.4)%

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the year ended December 31, 2014, our provision for doubtful accounts increased by $67.4 million, or 9.0%, to $817.8 million on a continuing operations basis and decreased by $10.9 million, or 1.5%, to $709.7 million on a same-hospital basis as compared to the prior year. Same-hospital self-pay revenues decreased by $106.8 million over the prior year. The decrease in same-hospital self-pay revenues is primarily due to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. However, as patient financial responsibility has continued to increase with higher co-payment and deductible obligations, our provision for doubtful accounts has increased to reflect the difficulty in collecting these amounts. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Critical Accounting Estimates."

Our net revenue days outstanding at December 31, 2014 improved to 56.4 days compared to 59.1 days at December 31, 2013 on a continuing operations basis. On a same-hospital basis, our net revenue days outstanding at December 31, 2014 improved to 57.2 days compared to 59.2 days at December 31, 2013.

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2014 and 2013:

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 2,134.5	47.6%	$ 1,727.4	47.0%	$ 407.1	23.6%
Man-hours per equivalent admission	108	N/A	107	N/A	1	0.9%
Salaries and benefits per equivalent admission	$ 3,870	N/A	$ 3,683	N/A	$ 187	5.1%

For the year ended December 31, 2014, our salaries and benefits expense increased to $2,134.5 million, or 23.6%, as compared to $1,727.4 million for the prior year primarily as a result of our recent acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2014 and 2013:

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 699.0	15.6%	$ 577.1	15.7%	$ 121.9	21.1%
Supplies per equivalent admission	$ 1,270	N/A	$ 1,232	N/A	$ 38	3.1%

For the year ended December 31, 2014, our supplies expense increased to $699.0 million, or 21.1%, as compared to $577.1 million for the prior year primarily as a result of our recent acquisitions.

Other Operating Expenses

The following table summarizes our other operating expenses for the years ended December 31, 2014 and 2013 (dollars in millions):

	Years Ended December 31,					
	2014	% of Revenues	2013	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 161.1	3.6%	$ 142.5	3.9%	$ 18.6	13.0%
Utilities	87.7	2.0	70.4	1.9	17.3	24.6
Repairs and maintenance	122.4	2.7	97.6	2.7	24.8	25.4
Rents and leases	45.4	1.0	36.5	1.0	8.9	24.3
Insurance	50.6	1.1	40.4	1.1	10.2	25.0
Physician recruiting	22.9	0.5	26.4	0.7	(3.5)	(13.3)
Contract services	319.7	7.1	256.4	7.0	63.3	24.7
Non-income taxes	124.2	2.8	102.0	2.8	22.2	21.8
Other	153.3	3.5	128.7	3.3	24.6	19.2
	$ 1,087.3	24.3	$ 900.9	24.4	$ 186.4	20.7%

For the year ended December 31, 2014, our other operating expenses increased to $1,087.3 million, or 20.7%, as compared to $900.9 million for the prior year primarily as a result of our recent acquisitions. Additionally, our same-hospital other operating expenses increased primarily as a result of increases in same-hospital contract services and other expenses. Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to the completion of our shared centralized resource initiatives at the majority of our hospitals. Our same-hospital other expenses increased as a result of additional transactional expenses related to our recent acquisitions, including legal and consulting fees.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2014, we recognized $71.9 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $64.1 million recognized in the prior year.

Depreciation and Amortization

For the year ended December 31, 2014, our depreciation and amortization expense increased by $22.3 million, or 9.8% to $250.5 million, or 5.6% of revenues, as compared to $228.2 million, or 6.2% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our recent acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions. However, many of our recent acquisitions' depreciation and amortization expense as a percentage of revenue is lower than the Company's historical rates.

Interest Expense

Our interest expense increased by $26.0 million, or 26.7%, to $123.0 million, for the year ended December 31, 2014, as compared to $97.0 million for the prior year. The increase in our interest expense is primarily attributable to an increase in our total debt outstanding during the year ended December 31, 2014 as compared to the prior year. On December 6, 2013, we issued in a private placement $700.0 million of our 5.5% Senior Notes. The net proceeds from this issuance were partially used to repay $100.0 million of our Incremental Term Loans. Subsequently, on May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes with terms substantially identical to those of the initial offering. The additional notes were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of our outstanding 3½% Notes. Including the impact of the premium, the additional 5.5% Senior Notes were issued at an effective rate of 4.9%. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charges

In connection with the sale of certain assets of River Parishes, effective November 1, 2014, and our entry into a definitive agreement to sell almost all of the assets of Lakeland, Northwest and Russellville, we recognized impairment charges in the aggregate of $57.7 million, $35.9 million net of income taxes, or $0.76 loss per diluted share, during the year ended December 31, 2014. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

Debt Transaction Costs

In connection with certain debt transactions and modifications completed during the year ended December 31, 2013, we recognized debt transaction costs of $5.9 million.

Gain on Settlement of Pre-Acquisition Contingent Obligation

In connection with an acquisition completed in 2012, we made reasonable estimates and recorded an estimated obligation representing the fair values of our potential contingent obligations to the seller pursuant to the asset purchase agreement. Subsequently, the seller finalized its settlement of certain of these obligations at an amount that was less than we originally estimated. As a result, during the year ended December 31, 2013, we reduced our originally recorded contingent obligations and recognized a gain of approximately $5.6 million.

Provision for Income Taxes

Our provision for income taxes was $68.1 million, or 1.5% of revenues, for the year ended December 31, 2014, as compared to $79.3 million, or 2.2% of revenues, for the prior year. The effective tax rate decreased to 35.1% for the year ended December 31, 2014, as compared to 38.3% for the prior year. Our effective tax rate was lower for the year ended December 31, 2014 as a result of the reversal of a $6.0 million valuation allowance that was established during 2013 against our deferred tax assets for federal net operating losses generated by our Michigan physician practice operations which were previously thought to be unrecoverable.

For the Years Ended December 31, 2013 and 2012

Operating Results Summary

The following table summarizes the results of operations for the years ended December 31, 2013 and 2012 (dollars in millions):

	Years Ended December 31,			
	2013		2012	
	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 4,428.7	120.4%	$ 4,016.2	118.4%
Provision for doubtful accounts	750.4	20.4	624.4	18.4
Revenues	3,678.3	100.0	3,391.8	100.0
Salaries and benefits	1,727.4	47.0	1,554.5	45.8
Supplies	577.1	15.7	524.6	15.5
Other operating expenses	900.9	24.4	799.1	23.5
Other income	(64.1)	(1.7)	(32.0)	(0.9)
Depreciation and amortization	228.2	6.2	193.1	5.7
Interest expense, net	97.0	2.6	100.0	3.0
Impairment charges	—	—	4.0	0.1
Debt transaction costs	5.9	0.2	4.4	0.1
Gain on settlement of pre-acquisition contingent obligation	(5.6)	(0.2)	—	—
	3,466.8	94.2	3,147.7	92.8
Income from continuing operations before income taxes	211.5	5.8	244.1	7.2
Provision for income taxes	79.3	2.2	88.5	2.6
Income from continuing operations	132.2	3.6	155.6	4.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(4.4)	(0.1)	(3.7)	(0.1)
Income from continuing operations attributable to LifePoint Hospitals, Inc.	$ 127.8	3.5%	$ 151.9	4.5%

Revenues

The following table presents the components of revenues for the years ended December 31, 2013 and 2012 (dollars in millions):

	Years Ended December 31,			
	2013	2012	Increase	% Increase
Revenues before provision for doubtful accounts	$4,428.7	$4,016.2	$ 412.5	10.3%
Provision for doubtful accounts	750.4	624.4	126.0	20.2
Revenues	$3,678.3	$3,391.8	$ 286.5	8.4

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2013 and 2012 (dollars in millions):

	Years Ended December 31,			
	2013		2012	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$1,199.5	32.6%	$1,170.3	34.5%
Medicaid	517.0	14.1	494.6	14.6
HMOs, PPOs and other private insurers	1,876.1	51.0	1,645.5	48.5
Self-pay	766.5	20.8	653.9	19.3
Other	69.6	1.9	51.9	1.5
Revenues before provision for doubtful accounts	4,428.7	120.4	4,016.2	118.4
Provision for doubtful accounts	(750.4)	(20.4)	(624.4)	(18.4)
Revenues	$3,678.3	100.0%	$3,391.8	100.0%

Our revenues per equivalent admission were as follows for the years ended December 31, 2013 and 2012:

	Years Ended December 31,			
	2013	2012	Increase	% Increase
Revenues per equivalent admission	$ 7,852	$ 7,491	$ 361	4.8

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the years ended December 31, 2013 and 2012:

	Years Ended December 31,			
	2013	2012	Increase (Decrease)	% Increase (Decrease)
Admissions	199,252	199,814	(562)	(0.3)
Equivalent admissions	468,441	452,779	15,662	3.5
Medicare case mix index	1.37	1.31	0.06	4.6
Average length of stay (days)	4.6	4.4	0.2	4.5
Inpatient surgeries	53,306	53,696	(390)	(0.7)
Outpatient surgeries	183,311	171,246	12,065	7.0
Total surgeries	236,617	224,942	11,675	5.2
Emergency room visits	1,171,537	1,149,301	22,236	1.9
Outpatient factor	2.35	2.27	0.08	3.8

For the year ended December 31, 2013, our revenues before provision for doubtful accounts from continuing operations increased by $412.5 million, or 10.3%, to $4,428.7 million as compared to $4,016.2 million for the prior year. This increase was primarily attributable to our acquisitions completed in 2013 and 2012 in addition to growth in our same-hospital revenues before provision for doubtful accounts from self-pay payors, higher contracted rates from HMOs, PPOs and other private insurers and an improvement in our appeal success results relating to Medicare recovery contractor audits.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the years ended December 31, 2013 and 2012 (dollars in millions):

	Years Ended December 31,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Related key indicators:						
Charity care write-offs	$ 132.1	3.6%	$ 112.5	3.3%	$ 19.6	17.5%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 766.5	20.8%	$ 653.9	19.3%	$ 112.6	17.2%
Net revenue days outstanding (at end of period)	59.1	N/A	54.7	N/A	4.4	8.0%

During the years ended December 31, 2013 and 2012, our provision for doubtful accounts related principally to amounts due from patients included in our self-pay population. For the year ended December 31, 2013, our provision for doubtful accounts increased by $126.0 million, or 20.2%, to $750.4 on a continuing operations basis as compared to the prior year. This increase was primarily the result of our acquisitions completed in 2013 and 2012 in addition to increases in self-pay revenues during the year ended December 31, 2013. Self-pay revenues increased by $112.6 million over the prior year and represented 20.8% of revenues as compared to 19.3% in the prior year. Self-pay revenues continued to increase for both our inpatient and outpatient services, which were primarily driven by higher self-pay volumes and pricing increases. Additionally, as a result of a decrease in our reimbursement under the New Mexico SCPP, we experienced an increase of approximately $17.7 million in our charity care write-offs during the year ended December 31, 2013, as compared to the prior year. Our increased provision for doubtful accounts was partially offset by an increase in both up-front cash collections and cash collections related to our insured receivables for the year ended December 31, 2013, as compared to the prior year. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Critical Accounting Estimates."

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2013 and 2012:

	Years Ended December 31,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$1,727.4	47.0%	$1,554.5	45.8%	$ 172.9	11.1%
Man-hours per equivalent admission	107	N/A	103	N/A	4	3.9%
Salaries and benefits per equivalent admission	$ 3,683	N/A	$ 3,424	N/A	$ 259	7.6%

For the year ended December 31, 2013, our salaries and benefits expense increased to $1,727.4 million, or 11.1%, as compared to $1,554.5 million for the prior year primarily as a result of our acquisitions completed in 2013 and 2012 and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2013 and 2012:

	Years Ended December 31,					
	2013	% of Revenues	2012	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 577.1	15.7%	$ 524.6	15.5%	$ 52.5	10.0%
Supplies per equivalent admission	$ 1,232	N/A	$ 1,158	N/A	$ 74	6.3%

For the year ended December 31, 2013, our supplies expense increased to $577.1 million, or 10.0%, as compared to $524.6 million for the prior year primarily a result of our acquisitions completed in 2013 and 2012.

Other Operating Expenses

The following table summarizes our other operating expenses for the years ended December 31, 2013 and 2012 (dollars in millions):

	Years Ended December 31,					
	2013	% of Revenues	2012	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 142.5	3.9%	$ 115.5	3.4%	$ 27.0	23.4%
Utilities	70.4	1.9	62.8	1.9	7.6	12.0
Repairs and maintenance	97.6	2.7	86.4	2.5	11.2	13.0
Rents and leases	36.5	1.0	34.3	1.0	2.2	6.6
Insurance	40.4	1.1	38.6	1.1	1.8	4.8
Physician recruiting	26.4	0.7	29.1	0.9	(2.7)	(9.1)
Contract services	256.4	7.0	219.3	6.5	37.1	16.9
Non-income taxes	102.0	2.8	89.8	2.6	12.2	13.6
Other	128.7	3.3	123.3	3.6	5.4	4.3
	$ 900.9	24.4	$ 799.1	23.5	$ 101.8	12.7%

For the year ended December 31, 2013, our other operating expenses increased to $900.9 million, or 12.7%, as compared to $799.1 million for the prior year primarily as a result of our acquisitions completed in 2013 and 2012. Additionally, our same-hospital other operating expenses increased primarily as a result of increases in same-hospital professional fees and contract services.

As a shortage of physicians continued to become more acute, we experienced increasing professional fees on both a continuing operations and same-hospital basis in areas such as emergency room physician coverage and hospitalists.

Our same-hospital contract services expense increased primarily as a result of increased fees and expenses related to our conversion of the clinical and patient accounting information system applications as well as the implementation of our shared centralized resource initiatives.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2013, we recognized $64.1 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $32.0 million in Medicaid EHR incentive payments recognized in the prior year.

Depreciation and Amortization

For the year ended December 31, 2013, our depreciation and amortization expense increased by $35.1 million, or 18.1% to $228.2 million, or 6.2% of revenues, as compared to $193.1 million, or 5.7% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our acquisitions completed in 2013 and 2012 as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Additionally, we have experienced increases in depreciation expense relating to capital improvement projects completed during 2013 and 2012.

Interest Expense

Our interest expense decreased by $3.0 million, or 3.1%, to $97.0 million, for the year ended December 31, 2013, as compared to $100.0 million for the prior year. Effective July 24, 2012, we replaced our prior credit agreement with the Senior Credit Agreement. Subsequently, on February 6, 2013, we amended our Senior Credit Agreement pursuant to which we issued the Incremental Term Loans, the proceeds from which were used to repurchase the 3¼% convertible senior subordinated debentures due August 15, 2025 (the "3¼% Debentures"). The decrease in our interest expense is primarily attributable to a decrease in the applicable effective interest on the Senior Credit Agreement for the year ended December 31, 2013 as compared to the applicable effective interest, including the amortization of debt discounts, on the prior credit agreement and the 3¼% Debentures. These decreases were partially offset by an increase in interest expense as a result of our issuance of the 5.5% Senior Notes on December 6, 2013. The net proceeds from this issuance were partially used to repay $100.0 million of the Incremental Term Loans. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charges

During the year ended December 31, 2012, we incurred a $4.0 million impairment charge from continuing operations. This impairment charge primarily related to the write-off of certain capitalized information system costs which we have determined are no longer a necessary component of our ongoing information technology strategy.

Debt Transaction Costs

In connection with certain debt transactions and modifications completed during the years ended December 31, 2013 and 2012, we recognized debt transaction costs of $5.9 million and $4.4 million, respectively.

Gain on Settlement of Pre-Acquisition Contingent Obligation

In connection with an acquisition completed in 2012, we made reasonable estimates and recorded an estimated obligation representing the fair values of our potential contingent obligations to the seller pursuant to the asset purchase agreement. Subsequently, the seller finalized its settlement of certain of these obligations at an amount that was less than we originally estimated. As a result, during the year ended December 31, 2013, we reduced our originally recorded contingent obligations and recognized a gain of approximately $5.6 million.

Provision for Income Taxes

Our provision for income taxes was $79.3 million, or 2.2% of revenues, for the year ended December 31, 2013, as compared to $88.5 million, or 2.6% of revenues, for the prior year. The effective tax rate increased to 38.3% for the year ended December 31, 2013, compared to 36.8% for the prior year as a result of a decrease in income from continuing operations for the year ended December 31, 2013 as compared to the prior year as well as several other factors. Our effective tax rate was higher for the year ended December 31, 2013 as a result of the recognition of a $6.0 million valuation allowance against our deferred tax assets for Federal net operating losses generated by our Michigan physician practice operations for which we did not believe we would be able to offset against future operational income. Additionally, our effective tax rate increased as a result of higher net state taxes due to the full year impact of Michigan operations and taxable income apportionment methodology in Michigan. These increases were partially offset by a decrease as a result of our utilization of certain other state net operating loss carry forwards.

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash flows provided by our operations and our debt borrowings. We believe that our internally generated cash flows and the amounts available under our Senior Credit Agreement will be adequate to service existing debt, finance internal growth and fund capital expenditures and certain small to mid-size hospital acquisitions.

The following table presents summarized cash flow information for the years ended December 31, 2014, 2013 and 2012 (in millions):

	2014	2013	2012
Net cash flows provided by continuing operations	$ 412.3	$ 354.1	$ 382.9
Less: Purchases of property and equipment	(207.1)	(185.2)	(221.4)
Free operating cash flow	205.2	168.9	161.5
Acquisitions, net of cash acquired	(265.6)	(188.1)	(199.7)
Proceeds from borrowings	412.0	1,053.0	555.0
Payments of borrowings	(585.4)	(453.7)	(469.3)
Repurchases of common stock	(222.3)	(39.1)	(95.5)
Payments of debt financing costs	(7.2)	(20.0)	(10.0)
Proceeds from exercise of stock options	23.9	39.2	21.8
Other	(7.0)	(7.3)	(5.0)
Net change in cash and cash equivalents	$(446.4)	$ 552.9	$ (41.2)

The non-GAAP metric of free operating cash flow is an important liquidity measure for us. Our computation of free operating cash flow consists of net cash flows provided by continuing operations less cash flows used for the purchase of property and equipment. We believe that free operating cash flow is useful to investors and management as a measure of the ability of our business to generate cash and to repay and incur additional debt. Computations of free operating cash flow may differ from company to company. Therefore, free operating cash flow should be used as a complement to, and in conjunction with, our consolidated statements of cash flows presented in our consolidated financial statements included elsewhere in this report.

Our cash flows provided by continuing operations for the year ended December 31, 2014 as compared to 2013 were positively impacted by higher net income, excluding the impact of certain non-cash charges, partially offset by an increase in our outstanding accounts receivable subsequent to our purchase at certain of our recently acquired facilities as a result of the time lag involved in obtaining provider numbers for the Medicare and Medicaid programs.

Our net cash flows provided by continuing operations for the year ended December 31, 2013 as compared to 2012 were negatively impacted by a decrease in the timing and amount of cash receipts for EHR incentive payments and certain other non-patient accounts receivables and an increase in the timing and amount of cash payments for certain obligations assumed in connection with our recent acquisitions. Additionally, our cash flows provided by continuing operations for the year ended December 31, 2012 were positively impacted by the receipt of approximately $33.0 million related to the Rural Floor Settlement. These factors were partially offset by an increase in the amount and timing of cash receipts for patient accounts receivable as well as an increase in the amount and timing of cash receipts for certain Medicare EHR incentive payments where we have demonstrated meaningful use of certified EHR technology for the applicable period but our recognition as other income has been deferred until the cost reporting period that determines the final calculation of EHR incentive payments has ended.

Capital Expenditures

We continue to make significant, targeted investments at our hospitals to add new technologies, modernize facilities and expand the services available. These investments should assist in our efforts to attract and retain physicians, to offset outmigration of patients and to make our hospitals more desirable to our employees and potential patients.

The following table reflects our capital expenditures for the years ended December 31, 2014, 2013 and 2012 (dollars in millions):

	2014	2013	2012
Capital and routine projects	$161.4	$128.3	$ 120.8
Information systems	45.7	56.9	100.6
	207.1	185.2	221.4
Depreciation expense	247.6	222.9	187.1
Ratio of capital expenditures to depreciation expense	83.6%	83.1%	118.3%

We have a formal and intensive review procedure for the authorization of capital expenditures that exceed an established threshold. One of the most important financial measures of acceptability for a discretionary capital project is whether its projected discounted cash flow return on investment exceeds our projected cost of capital for that project. We expect to continue to invest in information systems, modern technologies, emergency room and operating room expansions, the construction of medical office buildings for physician expansion and the reconfiguration of the flow of patient care. Additionally, we may from time to time replace existing hospital buildings with new buildings as we evaluate ongoing repair and maintenance costs and other factors that impact the future operations of the existing buildings.

Our total capital expenditures in 2014 were higher than in 2013 as a result of investments to modernize and expand the service-lines provided by our facilities. However, we spent less on information systems in 2014 as compared to 2013 as a result of our completion of a number of initiatives and our compliance with certain requirements of the HITECH Act. We expect the total level of spending for capital expenditures to be greater in 2015 as compared to 2014 as a result of our various capital commitments in connection with certain of our recent acquisitions.

Debt

An analysis and roll-forward of our long-term debt, including current maturities, during 2014 is as follows (in millions):

	December 31, 2013	Proceeds from Borrowings	Payments of Borrowings	Other[(a)]	Amortization of Debt Discounts and Premium	December 31, 2014
Senior Credit Agreement:						
Term Facility	$ 433.1	$ —	(11.2)	—	—	$ 421.9
Incremental Term Loans	222.6	—	—	—	—	222.6
6.625% Senior Notes	400.0	—	—	—	—	400.0
5.5% Senior Notes	700.0	400.0	—	—	—	1,100.0
3½% Notes	575.0	—	(574.2)	(0.8)	—	—
Unamortized debt discounts	(9.5)	—	—	—	8.5	(1.0)
Unamortized debt premium	—	12.0	—	—	(1.1)	10.9
Capital and financing leases	55.6	—	(1.9)	10.4	—	64.1
	$ 2,376.8	$ 412.0	$ (587.3)	$ 9.6	$ 7.4	$ 2,218.5

(a) Represents the $0.8 million difference between the original par value of the 3½% Notes and the cash settled conversion equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50, in addition to the assumption of capital lease obligations of approximately $10.4 million in connection with certain acquisitions completed during the year ended December 31, 2014.

We use leverage, or our total debt to total capitalization ratio, to make financing decisions. The following table illustrates our financial statement leverage and the classification of our debt at December 31, 2014 and 2013 (dollars in millions):

	December 31, 2014	December 31, 2013	Increase (Decrease)
Current portion of long-term debt	$ 19.2	$ 583.0	$ (563.8)
Long-term debt	2,199.3	1,793.8	405.5
Unamortized discounts on debt instruments	1.0	9.5	(8.5)
Unamortized premium on debt instrument	(10.9)	—	(10.9)
Total debt, excluding unamortized discounts and premium	2,208.6	2,386.3	(177.7)
Total LifePoint Hospitals, Inc. stockholders' equity	2,154.6	2,210.1	(55.5)
Total capitalization	$ 4,363.2	$ 4,596.4	$ (233.2)
Total debt to total capitalization	50.6%	51.9%	(130) bps
Percentage of:			
Fixed rate debt, excluding unamortized discount and premium	70.8%	72.5%	
Variable rate debt, excluding unamortized discount	29.2	27.5	
	100.0%	100.0%	
Percentage of:			
Senior debt, excluding unamortized discount and premium	100.0%	75.9%	
Subordinated debt, excluding unamortized discount	—	24.1	
	100.0%	100.0%	

Liquidity and Capital Resources Outlook

Our total capital expenditures in 2014 were higher than in 2013 as a result of investments to modernize and expand the service-lines provided by our facilities. However, we spent less on information systems in 2014 as compared to 2013 as a result of our completion of a number of initiatives and our compliance with certain requirements of the HITECH Act. We expect the total level of spending for capital expenditures to be greater in 2015 as compared to 2014 as a result of our various capital commitments in connection with certain of our recent acquisitions.

At December 31, 2014, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $66.1 million. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the Senior Credit Agreement.

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. These acquisitions may, however, require additional financing. We regularly evaluate opportunities to sell additional equity or debt securities, obtain credit agreements from lenders or restructure our long-term debt or equity for strategic reasons or to further strengthen our financial position. The sale of additional equity or convertible debt securities could result in additional dilution to our stockholders.

We believe that cash generated from our operations and borrowings available under the Senior Credit Agreement will be sufficient to meet our working capital needs, the purchase prices for any potential facility acquisitions, planned capital expenditures and other expected operating needs over the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding debt.

Contractual Obligations, Commitments and Off-Balance Sheet Arrangements

Contractual Obligations

We have various contractual obligations, which are recorded as liabilities in our consolidated financial statements. Other items, such as certain purchase commitments and other executory contracts, are not recognized as liabilities in our consolidated financial statements but are required to be disclosed. For example, we are required to make certain minimum lease payments for the use of property under certain of our operating lease agreements.

The following table summarizes our significant contractual obligations as of December 31, 2014 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payment Due by Period				
Contractual Obligations	**Total**	**2015**	**2016 – 2017**	**2018 – 2019**	**After 2019**
Long-term debt obligations[a]	$ 2,768.1	$ 120.3	$ 826.3	$ 174.0	$ 1,647.5
Capital expenditure obligations[b]	1,646.8	164.2	318.0	262.9	901.7
Capital and financing lease obligations[c]	101.5	8.3	15.5	14.8	62.9
Operating lease obligations[d]	125.7	26.4	35.8	32.8	30.7
Other long-term liabilities[e]	194.9	48.3	61.4	39.6	45.6
Purchase obligations[f]	1,053.2	276.2	379.2	208.0	189.8
Total	$ 5,890.2	$ 643.7	$ 1,636.2	$ 732.1	$ 2,878.2

(a) Included in long-term debt obligations are principal and interest owed on our outstanding debt obligations. These amounts exclude our unamortized debt discount and premium and related non-cash amortization. These obligations are explained further in Note 5 to our consolidated financial statements included elsewhere in this report. We used the 2.17% and 2.67% effective interest rates at December 31, 2014 for our $421.9 million outstanding senior secured term loan facility (the "Term Facility") and $222.6 million outstanding Incremental Term Loans, respectively, to estimate interest payments on these variable rate debt instruments.

(b) We are subject to annual capital expenditure commitments in connection with several of our facilities including our recent acquisitions. Additionally, we had projects under construction with an estimated additional cost to complete and equip of approximately $66.1 million as of December 31, 2014. However, because we can terminate substantially all of the related construction contracts at any time without paying a termination fee, these costs are excluded from the above table except for amounts contractually committed by us.

(c) Included in capital and financing lease obligations are the future cash payments, including interest, due under our capital and financing lease agreements. These obligations are explained further in Note 11 to our consolidated financial statements included elsewhere in this report.

(d) This reflects our future minimum operating lease payments. We enter into operating leases in the normal course of business. Substantially all of our operating lease agreements have fixed payment terms based on the passage of time. Some lease agreements provide us with the option to renew the lease. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. These obligations are explained further in Note 11 to our consolidated financial statements included elsewhere in this report.

(e) Included in other long-term liabilities are the current and long-term portions of our reserves for self-insurance claims of $44.3 million and $133.2 million, respectively, but excluding the portion of the reserve related to our estimate of recoveries for certain claims in excess of our self-insured retention levels that do not require us to make cash payments. Please refer to "Critical Accounting Estimates — Reserves for Self-Insurance Claims" in this report for more information on our reserves for self-insurance claims. Additionally, included in other long-term liabilities are the estimated cash contributions we expect to make to our defined benefit pension plans sufficient to meet our minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended, and our other long-term obligations which require the delivery of cash and for which we can reasonably estimate the timing of such payments.

(f) The following table summarizes our significant purchase obligations as of December 31, 2014 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payment Due by Period				
Purchase Obligations	**Total**	**2015**	**2016 – 2017**	**2018 – 2019**	**After 2019**
Shared centralized resource model agreements[g]	$ 486.1	$ 62.6	$ 124.7	$ 122.5	$ 176.3
IT services[h]	178.2	48.8	97.2	21.7	10.5
GEMS obligations[i]	136.4	34.1	68.2	34.1	—
Other purchase obligations[j]	252.5	130.7	89.1	29.7	3.0
Total	$ 1,053.2	$ 276.2	$ 379.2	$ 208.0	$ 189.8

(g) We have various arrangements with a third party to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle functions under a shared centralized resource model for periods ranging from three to eight years.

(h) We have various arrangements with third parties to provide information technology services, including, but not limited to, financial, clinical, patient accounting and other information services to us under contracts ranging from two to six years.

(i) General Electric Medical Services ("GEMS") provides diagnostic imaging equipment maintenance and bio-medical services to us pursuant to a contract that expires on December 31, 2018.

(j) Reflects our minimum commitments to purchase goods or services under non-cancelable contracts as of December 31, 2014.

Off-Balance Sheet Arrangements

We had standby letters of credit outstanding of approximately $22.4 million as of December 31, 2014, all of which relates to the self-insured retention levels of our professional and general liability insurance and workers' compensation programs as security for the payment of claims.

Recently Issued Accounting Pronouncements

ASU No. 2014-9, "Revenue from Contracts with Customers"

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-9, "Revenue from Contracts with Customers" ("ASU 2014-9"). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, "Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities." The provisions of ASU 2014-9 are effective for annual periods beginning after December 15, 2016, including interim periods within those years. Early adoption is not permitted. We are currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, result of operations, cash flows, financial disclosures and control framework.

ASU No. 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment — Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity"

In April 2014, the FASB issued ASU No. 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment - Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-8"). Among other provisions and in addition to expanded disclosures, ASU 2014-8 changes the definition of what components of an entity qualify for discontinued operations treatment and reporting from a reportable segment, operating segment, reporting unit, subsidiary or asset group to only those components of an entity that represent a strategic shift that has, or will have, a major effect on an entity's operations and financial results. Additionally, ASU 2014-8 requires disclosure about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements, including the pretax profit or loss, attributable to the component of an entity for the period in which it is disposed of or is classified as held for sale. The disclosure of this information is required for all of the same periods that are presented in the entity's results of operations for the period.

As more fully discussed in Note 3 to our consolidated financial statements included elsewhere in this report, during the year ended December 31, 2014, we sold certain assets of River Parishes and discontinued its operation, in addition to entering into a definitive agreement to sell almost all of the assets of Lakeland, Northwest and Russellville. We have determined that none of the aforementioned divestitures qualify for discontinued operations treatment in accordance with the provisions of ASU 2014-8. However, we have provided the additional required disclosures.

Critical Accounting Estimates

The preparation of financial statements in accordance with GAAP requires us to make estimates and assumptions that affect reported amounts and related disclosures. We consider an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations or financial condition.

Our management has discussed the development and selection of these critical accounting estimates with the audit committee of our Board of Directors and with our independent registered public accounting firm, and they both have reviewed our disclosure relating to our critical accounting estimates. Our critical accounting estimates include the following areas:

- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Reserves for self-insurance claims;
- Accounting for stock-based compensation; and
- Accounting for income taxes.

The following discussion of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 1 to our consolidated financial statements included elsewhere in this report, the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and our financial condition.

The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate.

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which services are provided. Accounts receivable primarily consist of amounts due from third-party payors and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs, such as Medicare and Medicaid, and other third-party payors such as HMOs, PPOs and other private insurers, are generally less than our established billing rates. Additionally, to provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Accordingly, our revenues and accounts receivable are reduced to net realizable value through an allowance for contractual discounts and a provision for doubtful accounts.

Approximately 99.4%, 97.7% and 97.6% of our revenues during the years ended December 31, 2014, 2013 and 2012, respectively, relate to discounted charges, which were comprised of the following sources (as a percentage of revenues):

	2014	2013	2012
Medicare	30.4%	32.6%	34.5%
Medicaid	13.8	14.1	14.6
HMO's, PPO's and other private insurers	55.2	51.0	48.5

Revenues are recorded at estimated net amounts due from patients, third-party payors and others for healthcare services provided. For certain payors, such as Medicare, Medicaid, as well as some managed care payors with which we have contractual arrangements, the contractual allowances are calculated by computerized logging systems based on defined payment terms. For other payors, the contractual allowances are determined based on historical data by insurance plan. All contractual adjustments, regardless of type of payor or method of calculation, are reviewed and compared to actual experience.

We monitor our processes for calculating contractual allowances through:

- review of payment discrepancy reports for logged payors;
- analysis of historical contractual allowance trends based on actual claims paid by HMOs, PPOs and other private insurers;
- review of contractual allowance information reflecting current contract terms;
- consideration and analysis of changes in charge rates and payor mix reimbursement levels; and
- other issues that may impact contractual allowances.

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely. Adjustments related to final settlements increased our revenues by $2.5 million, $5.6 million and $7.0 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Because the laws and regulations governing the Medicare and Medicaid programs are complex and subject to change, the estimates of contractual discounts we record could change by material amounts. A significant increase in our estimate of contractual discounts for Medicare and Medicaid would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

HMOs, PPOs and Other Private Insurers

Amounts we receive for the treatment of patients covered by HMOs, PPOs and other private insurers (collectively "managed care plans") are generally less than our established billing rates. We include contractual allowances as a reduction to revenues in our consolidated financial statements based on payor specific identification and payor specific factors for rate increases and denials. For most managed care plans, estimated contractual allowances are adjusted to actual contractual allowances as cash is received and claims are reconciled.

If our overall estimated contractual discount percentage on our managed care program revenues for the year ended December 31, 2014 were changed by 1%, our after-tax income from continuing operations would change by approximately $30.1 million, or diluted earnings per share of $0.64. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received based on payor contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Provision and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts. Our allowance for doubtful accounts, included in our consolidated balance sheets as of December 31, 2014 and 2013 was $709.5 million and $741.2 million, respectively. Our provision for doubtful accounts, included in our consolidated results of operations for the years ended December 31, 2014, 2013 and 2012, was $817.8 million, $750.4 million and $624.4 million, respectively.

The largest component of our allowance for doubtful accounts relates to accounts for which patients are responsible, which we refer to as patient responsibility accounts or self-pay accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. In general, we attempt to collect deductibles, co-payments and self-pay accounts prior to the time of service for non-emergency care. If we do not collect these patient responsibility accounts prior to the delivery of care, the accounts are handled through our billing and collections processes.

The approximate amounts and percentages of billed insured and uninsured (including self-pay, co-payments, deductibles and Medicaid pending) gross accounts receivable (prior to allowance for contractual discounts and allowance for doubtful accounts) in summarized aging categories are as follows for the periods presented (in millions):

	December 31, 2014					
	Insured Receivables		Uninsured Receivables		Combined	
	Amount	Percent of Receivables	Amount	Percent of Receivables	Amount	Percent of Receivables
0 to 90 days	$ 966.2	82.5%	$ 240.9	26.2%	$ 1,207.1	57.8%
91 to 150 days	111.9	9.6	159.9	17.4	271.8	13.0
151 to 360 days	74.0	6.3	413.9	45.1	487.9	23.4
Over 361	18.7	1.6	103.5	11.3	122.2	5.8
	$ 1,170.8	100.0%	$ 918.2	100.0%	$ 2,089.0	100.0%

	December 31, 2013					
	Insured Receivables		Uninsured Receivables		Combined	
	Amount	Percent of Receivables	Amount	Percent of Receivables	Amount	Percent of Receivables
0 to 90 days	$ 500.6	83.6%	$ 249.8	27.1%	$ 750.4	49.3%
91 to 150 days	52.5	8.8	155.7	16.9	208.2	13.7
151 to 360 days	34.7	5.8	354.2	38.4	388.9	25.6
Over 361	10.9	1.8	163.2	17.6	174.1	11.4
	$ 598.7	100.0%	$ 922.9	100.0%	$ 1,521.6	100.0%

We verify each patient's insurance coverage as early as possible before a scheduled admission or procedure, including with respect to eligibility, benefits and authorization/pre-certification requirements, in order to notify patients of the amounts for which they will be responsible. We attempt to verify insurance coverage within a reasonable amount of time for all emergency room visits and urgent admissions in compliance with EMTALA.

In general, we perform the following steps in collecting accounts receivable:

- if possible, cash collection of deductibles, co-payments and self-pay accounts prior to or at the time service is provided;
- billing and follow-up with third party payors;
- collection calls;
- utilization of collection agencies; and
- if collection efforts are unsuccessful, write-off of the accounts.

Our policy is to write-off accounts after all collection efforts have failed, which is generally one year after the date of discharge of the patient. Patient responsibility accounts represent the majority of our write-offs. All of our hospitals retain third-party collection agencies for billing and collection of delinquent accounts. At most of our hospitals, more than one collection agency is used to promote competition and improve performance results. The selection of collection agencies and the timing of referral of an account to a collection agency vary among our hospitals.

We determine the adequacy of the allowance for doubtful accounts utilizing a number of analytical tools and benchmarks. No single statistic or measurement alone determines the adequacy of the allowance. Specifically, we monitor the revenue trends by payor classification on a month-by-month basis along with the composition of our accounts receivable agings. This review is focused primarily on trends in self-pay revenues, accounts receivable, co-payment receivables, historic payment patterns and other factors such as revenue days in accounts receivable.

The process of determining our allowance for doubtful accounts requires us to estimate uncollectible self-pay accounts. Our estimate of uncollectible self-pay accounts is primarily based on our collection history, adjusted for anticipated changes in collection trends, if significant. Our estimate may be impacted by changes in regional economic conditions, business office operations, payor mix and trends in federal or state governmental healthcare coverage or other third party payors. If the actual self-pay collection percentage would change by 1.5% from our estimated self-pay collection percentage for the year ended December 31, 2014, our after-tax income from continuing operations would change by approximately $7.3 million, or diluted earnings per share of $0.15, and our net accounts receivable would change by $3.0 million at December 31, 2014. The resulting change in this analytical tool is considered to be a reasonably likely change that would affect our overall assessment of this critical accounting estimate.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheets as of December 31, 2014 and 2013 was $1,636.1 million and $1,651.0 million, respectively. Please refer to Note 4 to our consolidated financial statements included elsewhere in this report for a detailed rollforward of our goodwill.

In accordance with ASC 350-10, "Intangibles — Goodwill and Other" ("ASC 350-10") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Our business comprises a single operating reporting unit for impairment test purposes. For the purposes of these analyses, our estimate of fair value are based on a combination of the income approach, which estimates the fair value of us based on our future discounted cash flows, and the market approach, which estimates the fair value of us based on comparable market prices. Our estimate of future discounted cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. During the years ended December 31, 2014, 2013 and 2012, we performed our annual impairment tests as of October 1, and did not incur an impairment charge.

Reserves for Self-Insurance Claims

We are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention level. Our self-insured retention level for professional liability claims is $5.0 million per claim at December 31, 2014 with a $5.0 million inner aggregate per claim. Our self-insured retention level is evaluated annually as a part of our insurance program's renewal process.

Additionally, as of December 31, 2014, our self-insured retention level for workers' compensation claims is $1.0 million per claim in all states in which we operate except for Wyoming. We participate in a state specific program in Wyoming for our workers' compensation claims arising in this state.

Each year, we obtain quotes from various insurers with respect to the cost of obtaining insurance coverage. We compare these quotes to our most recent actuarially determined estimates of losses at various self-insured retention levels. Accordingly, changes in insurance costs affect the self-insured retention level we choose each year.

Our reserves for self-insurance claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. Our expense for self-insurance claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of our self-insured retention levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability.

Our reserves for professional liability claims are based upon quarterly actuarial calculations. Our reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.50%, 1.55% and 1.80% at December 31, 2014, 2013 and 2012, respectively. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2014 and 2013 (in millions):

	December 31, 2014	December 31, 2013
Undiscounted	$ 186.2	$ 176.5
Discounted (as reported)	$ 177.5	$ 168.0

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2014, 2013 and 2012 (in millions):

	2014	2013
Reserve at the beginning of the period	$ 168.0	$ 160.2
Increase for the provision of current year claims, including discontinued operations	55.1	51.3
Decrease for the provision of prior year claims, including discontinued operations	(5.2)	(12.9)
Payments related to current year claims	(3.5)	(4.3)
Payments related to prior year claims	(35.3)	(32.3)
Provision for the change in discount rate	0.3	1.4
Professional liability claims assumed as a result of acquisition	—	2.4
Noncash change in reserve for claims in excess of self-insured retention levels	(1.9)	2.2
Reserve at the end of the period	$ 177.5	$ 168.0

As of December 31, 2014 and 2013, less than 1% of our reserves for self-insured claims represents reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

Our estimated reserves for self-insured claims will be significantly affected if current and future claims differ from historical trends. While we monitor reported claims closely and consider potential outcomes when determining our reserves for self-insured claims, the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes complicates the estimation process. In addition, certain states have passed varying forms of tort reform which attempt to limit the amount of awards. If such laws are passed in the states where our hospitals are located, our loss estimates could decrease.

Our estimate of reserves for self-insured claims are based upon actuarial calculations and are significantly influenced by key assumptions and other factors. These factors include, but are not limited to: historical paid claims; trending of loss development factors; trends in the frequency and severity of claims, which can differ significantly by jurisdiction as a result of the legislative and judicial climate in such jurisdictions; coverage limits of third-party insurance and actuarial determined statistical confidence levels. Given the number of assumptions and characteristics of each assumption considered in establishing the reserves for self-insured claims, it is difficult to compute the individual financial impact of each assumption or groups of assumptions. Some of the assumptions are dependent upon the quantitative measurement of other assumptions, and therefore are not accurately evaluated in isolation. For example, a change in the frequency of claims assumption is also affected by the estimated severity of these claims resulting in an inability to properly isolate and quantify the impact of a change in this assumption.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Our reserves for self-insured claims are comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period. We have the ability to reliably determine the amount and timing of payments based on sufficient history of our claims development, the use of external actuarial expertise and our rigorous review process. Actuarial payment patterns are based on our individual hospital historical data both prior to and after our inception in 1999. The processes, performed by both external actuaries and our management, enable us to reliably determine the amount of our ultimate losses as well as the timing of the loss settlements such that discounting of the reserves for self-insured claims is appropriate. Given the number of factors considered in establishing the reserves for self-insured claims, it is neither practical nor meaningful to isolate a particular assumption or parameter of the process and calculate the impact of changing that single item.

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes a statistical confidence level that is 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The assumptions included in the table below are presented for the sensitivity analysis (in millions):

December 31, 2014 reserve:		
As reported	$	177.5
With 70% Confidence Level	$	187.4
With 80% Confidence Level	$	198.0
With 90% Confidence Level	$	227.0
December 31, 2013 reserve:		
As reported	$	168.0
With 70% Confidence Level	$	181.3
With 80% Confidence Level	$	191.6
With 90% Confidence Level	$	219.9

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annually completed actuarial calculations decreased our self-insured claims expense by $5.1 million, $12.9 million and $9.1 million, which increased our net income by approximately $3.3 million, $7.9 million and $5.8 million, or $0.07, $0.17 and $0.12 per diluted share, during the years ended December 31, 2014, 2013 and 2012, respectively.

Accounting for Stock-Based Compensation

We issue stock-based awards, including stock options, appreciation rights and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with our various stockholder-approved stock-based compensation plans. We account for our stock-based awards in accordance with the provisions of ASC 718-10, "Compensation — Stock Compensation" ("ASC 718-10") and accordingly recognize compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value. Our stock-based compensation expense was $29.7 million, $25.4 million and $27.4 million for the years ended December 31, 2014, 2013 and 2012, respectively.

We estimate the fair value of stock options granted using the Hull-White II Valuation Model ("HW-II") lattice option valuation model and a single option award approach. We use the HW-II because it considers characteristics of fair value option pricing, such as an option's contractual term and the probability of exercise before the end of the contractual term. In addition, the complications surrounding the expected term of an option are material, as indicated in ASC 718-10. Given our reasonably large pool of unexercised options, we believe a lattice model that specifically addresses this fact and models a full term of exercises is the most appropriate and reliable means of valuing our stock options. We are amortizing the fair value on a straight-line basis over the requisite service periods of the awards, which are the vesting periods of three years. The stock options vest 33.3% on each grant anniversary date over three years of continued employment.

The following table shows the weighted average assumptions we used to develop the fair value estimates under our HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
Expected volatility	29.0%	30.8%	36.0%
Risk-free interest rate, minimum	0.05	0.02	0.03
Risk-free interest rate, maximum	2.71	2.90	1.97
Expected dividends	—	—	—
Average expected term (years)	5.4	5.3	5.3
Fair value per share of stock options granted	$13.95	$11.98	$ 12.18

Population Stratification

In accordance with ASC 718-10, a company should aggregate individual awards into relatively homogeneous groups with respect to exercise and post-vesting employment behaviors for the purpose of refining the expected term assumption, regardless of the valuation technique used to estimate the fair value. In addition, ASC 718-10 indicates that a company may generally make a reasonable fair value estimate with as few as one or two groupings. We have determined that a single employee population group is appropriate based on an analysis of our historical exercise patterns.

Expected Volatility

Volatility is a measure of the tendency of investment returns to vary around a long-term average rate. Historical volatility is an appropriate starting point for setting this assumption in accordance with ASC 718-10. According to ASC 718-10, companies should also consider how future experience may differ from the past. This may require using other factors to adjust historical volatility, such as implied volatility, peer-group volatility and the range and mean-reversion of volatility estimates over various historical periods. ASC 718-10 acknowledges that there is likely to be a range of reasonable estimates for volatility. In addition, ASC 718-10 requires that if a best estimate cannot be made, management should use the mid-point in the range of reasonable estimates for volatility. We estimate the volatility of our common stock at the date of grant based on both historical volatility and implied volatility from traded options of our common stock, consistent with ASC 718-10.

Risk-Free Interest Rate

Lattice models require risk-free interest rates for all potential times of exercise obtained by using a grant-date yield curve. A lattice model would, therefore, require the yield curve for the entire time period during which employees might exercise their options. We base the risk-free rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Dividends

We have never paid any cash dividends on our common stock and do not anticipate paying any cash dividends in the foreseeable future. Accordingly, we use an expected dividend yield of zero.

Pre-Vesting Forfeitures

Pre-vesting forfeitures do not affect the fair value calculation, but they affect the expense calculation. ASC 718-10 requires us to estimate pre-vesting forfeitures at the time of grant and revise those estimates in subsequent periods if actual forfeitures differ from those estimates. We use historical data to estimate pre-vesting forfeitures and record share-based compensation expense only for those awards that are expected to vest.

We apply a dynamic forfeiture rate methodology over the vesting period of the award. The dynamic forfeiture rate methodology incorporates the lapse of time into the resulting expense calculation and results in a forfeiture rate that diminishes as the granted awards approach its vest date. Accordingly, the dynamic forfeiture rate methodology results in a more consistent stock compensation expense calculation over the vesting period of the award.

Post-Vesting Cancellations

Post-vesting cancellations include vested options that are cancelled, exercised or expire unexercised. Lattice models treat post-vesting cancellations and voluntary early exercise behavior as two separate assumptions. We use historical data to estimate post-vesting cancellations.

Expected Term

ASC 718-10 calls for an extinguishment calculation, dependent upon how long a granted option remains outstanding before it is fully extinguished. While extinguishment may result from exercise, it can also result from post-vesting cancellation or expiration at the contractual term. Expected term is an output in lattice models so we do not have to determine this amount.

The fair value calculations of our stock option grants are affected by assumptions that are believed to be reasonable based upon the facts and circumstances at the time of grant. Changes in our volatility estimates can materially affect the fair values of our stock option grants. If our estimated weighted-average volatility for the year ended December 31, 2014 were 10% higher, our after-tax income from continuing operations would decrease by approximately $0.5 million, or $0.01 per diluted share.

Generally, the fair value of our other stock-based awards is determined based on the closing price of our common stock on the trading date immediately prior to the grant date. However, of the other stock-based awards granted during the year ended December 31, 2014, 236,000 were performance-based awards. In addition to requiring continuing service of the employee, the percentage of these awards that are earned at the end of the performance period is determined based on our three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. The number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved. For valuation purposes, the awards were bifurcated into their two independent sub-award components for the portion that would be settled in our common stock and for the portion that would be settled in cash and their respective fair values were estimated using the Monte-Carlo simulation valuation model. We recognize compensation expense for the portion of the award that would ultimately be settled in our common stock for the targeted units at its Monte-Carlo simulation value if the requisite service period is rendered, even if the market condition is never satisfied.We classify as a liability and recognize compensation expense for the portion of the award that would ultimately be settled in cash for the targeted units at its Monte-Carlo simulation value that has been and will continue to be marked-to-market until settlement.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $280.7 million and $330.1 million as of December 31, 2014 and 2013, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $66.4 million and $66.8 million as of December 31, 2014 and 2013, respectively.

In addition, significant judgment is required in determining and assessing the impact of certain tax-related contingencies. We establish accruals when, despite our belief that our tax return positions are fully supportable, it is probable that we have incurred a loss related to tax contingencies and the loss or range of loss can be reasonably estimated. We adjust the accruals related to tax contingencies as part of our provision for income taxes in our results of operations based upon changing facts and circumstances, such as progress of a tax audit, development of industry related examination issues, as well as legislative, regulatory or judicial developments. A number of years may elapse before a particular matter, for which we have established an accrual, is audited and resolved.

The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction.

The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

In assessing tax contingencies, we apply the provisions of ASC 740-10, "Income Taxes". We apply the recognition threshold and measurement of a tax position taken or expected to be taken in a tax return and follow the guidance on various matters such as derecognition, interest, penalties and disclosure. We classify interest and penalties as a component of income tax expense.

During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.

Our deferred tax liabilities exceeded our deferred tax assets by $48.3 million as of December 31, 2014, excluding the impact of valuation allowances. Historically, we have produced federal taxable income, and as such, we believe that the likelihood of not realizing the federal tax benefit of our deferred tax assets is remote. However, we do have subsidiaries with a history of tax losses in certain state jurisdictions and, based upon those historical tax losses, we assumed that the subsidiaries would not be profitable in the future for those states' tax purposes. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the state valuation allowance of $66.0 million at December 31, 2014.

The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable income for 2014, we would incur approximately $5.8 million of additional tax payments for 2014 plus interest and penalties, if applicable.

Segment Reporting

We have three operating groups as of December 31, 2014. We realign these operating groups frequently based upon changing circumstances, including acquisition and divestiture activity. We consider these three operating groups as one operating segment, healthcare services, for segment reporting purposes and as one reporting unit for goodwill impairment testing in accordance with ASC 280-10, "Segment Reporting" ("ASC 280-10"), and ASC 350-10.

In accordance with ASC 350-10, we determined that our three operating groups and related acute care hospitals comprise one reporting unit because of their similar economic characteristics in each of the following areas:

- the way we manage our operations and extent to which our acquired facilities are integrated into our existing operations as a single reporting unit;
- our goodwill is recoverable from the collective operations of our three operating groups and related acute care hospitals and not individually from one single operating group or hospital;
- our operating groups are frequently realigned based upon changing circumstances, including acquisition and divestiture activity; and
- because of the collective size of our three operating groups, each group and acute care hospital benefits from its participation in a group purchasing organization.

Inflation

The healthcare industry is labor-intensive. Wages and other expenses increase during periods of inflation and when labor shortages in marketplaces occur. In addition, suppliers pass along rising costs to us in the form of higher prices. Private insurers pass along their rising costs in the form of lower reimbursement to us.

Our ability to pass on these increased costs in increased rates is limited because of increasing regulatory and competitive pressures and the fact that the majority of our revenues are fee-based. Accordingly, inflationary pressures could have a material adverse effect on our results of operations.

Item 7A. *Quantitative and Qualitative Disclosures about Market Risk.*

Interest Rates

The following discussion relates to our exposure to market risk based on changes in interest rates:

Outstanding Debt

As of December 31, 2014, we had outstanding debt, excluding a $1.0 million unamortized discount and a $10.9 million unamortized premium, of $2,208.6 million, 29.2%, or $644.5 million, of which was subject to variable rates of interest.

The carrying amounts and fair values of the Term Facility and the Incremental Term Loans under the Senior Credit Agreement, the 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), the 5.5% Senior Notes and the 3½% Notes as of December 31, 2014 and December 31, 2013 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2014	December 31, 2013	December 31, 2014	December 31, 2013
Senior Credit Agreement:				
Term Facility	$ 421.9	$ 433.1	$ 420.3	$ 434.2
Incremental Term Loans, excluding unamortized discount	$ 222.6	$ 222.6	$ 222.0	$ 224.2
6.625% Senior Notes	$ 400.0	$ 400.0	$ 422.0	$ 425.0
5.5% Senior Notes, excluding unamortized premium	$ 1,100.0	$ 700.0	$ 1,130.3	$ 703.5
3½% Notes, excluding unamortized discount	$ —	$ 575.0	$ —	$ 622.4

The fair values of the Term Facility, the Incremental Term Loans, the 6.625% Senior Notes and the 5.5% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, "Fair Value Measurements and Disclosures" ("ASC 820-10"). The fair values of the 3½% Notes were estimated based on the quoted market prices determined using the closing share price of our common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. As more fully discussed in Note 5 to our consolidated financial statements included elsewhere in this report, effective May 12, 2014, we issued $400.0 million of additional 5.5% Senior Notes at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million. The net proceeds from this additional issuance were used to fund, in part, the cash-settled portion of the maturity or conversion of the 3½% Notes on or before May 15, 2014.

Cash Balances

Certain of our outstanding cash balances are invested overnight with high credit quality financial institutions. We do not hold direct investments in auction rate securities, collateralized debt obligations, structured investment vehicles or mortgage-backed securities. We do not have significant exposure to changing interest rates on invested cash at December 31, 2014. As a result, the interest rate market risk implicit in these investments at December 31, 2014, if any, is low.

Item 8. *Financial Statements and Supplementary Data.*

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this report.

Item 9. *Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.*

We did not experience a change in or disagreement with our accountants during the year ended December 31, 2014.

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Item 9A. ***Controls and Procedures.***

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

We carried out an evaluation, under the supervision and with the participation of management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report pursuant to Rule 13a-15 of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us (including our consolidated subsidiaries) in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported on a timely basis.

Pursuant to Section 404 of the Sarbanes-Oxley Act of 2002, we have included a report of management's assessment of the design and operating effectiveness of our internal controls as part of this report. Our independent registered public accounting firm also attested to, and reported on, the effectiveness of internal control over financial reporting. Management's report and the independent registered public accounting firm's attestation report are included in our consolidated financial statements beginning on page F-1 of this report under the captions entitled "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm."

Changes in Internal Control Over Financial Reporting

There has been no change in our internal control over financial reporting during the fourth quarter ended December 31, 2014 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. ***Other Information.***

None.

PART III

Item 10. *Directors, Executive Officers and Corporate Governance.*

Executive Officers

This information is incorporated by reference to the information contained under the caption "Executive Compensation — Executive Officers of the Company" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Code of Ethics

Our Board of Directors expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as "Common Ground," and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer (the "Code of Ethics"). The Code of Ethics and Common Ground are posted on our website located at *www.lifepointhospitals.com* under the heading "Corporate Governance." We intend to disclose any amendments to our Code of Ethics and any waiver from a provision of our code, as required by the SEC, on our website within four business days following such amendment or waiver.

Directors

This information is incorporated by reference to the information contained under the caption "Proposal 1: Election of Directors" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Compliance with Section 16(a) of the Exchange Act

This information is incorporated by reference to the information contained under the caption "Ownership of Equity Securities of the Company — Section 16(a) Beneficial Ownership Reporting Compliance" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Stockholder Nominees

This information is incorporated by reference to the information contained under the caption "Proposal 1: Election of Directors — Director Nomination Process" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Audit and Compliance Committee

This information is incorporated by reference to the information contained under the caption "Audit and Compliance Committee Report" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Item 11. *Executive Compensation.*

This information is incorporated by reference to the information contained under the captions "Compensation Committee Report," "Compensation Discussion and Analysis," "Executive Compensation," "Corporate Governance — Compensation Committee Interlocks and Insider Participation," and "Director Compensation," included in our proxy statement relating to our 2015 annual meeting of stockholders.

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.*

This information is incorporated by reference to the information contained under the captions "Ownership of Equity Securities of the Company" and "Executive Compensation — Potential Payments upon Termination or Change in Control" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Information concerning our equity compensation plans is included in Part II, Item 5. of this report under the caption "Equity Compensation Plan Information."

Item 13. ***Certain Relationships and Related Transactions, and Director Independence.***

This information is incorporated by reference to the information contained under the captions "Corporate Governance — Independence and Related Person Transactions" and "Corporate Governance — Board Meetings and Committees" included in our proxy statement relating to our 2015 annual meeting of stockholders.

Item 14. ***Principal Accountant Fees and Services.***

This information is incorporated by reference to the information contained under the caption "Proposal 2: Ratification of Selection of Independent Registered Public Accounting Firm" and "Fees and Services of the Independent Registered Public Accounting Firm" included in our proxy statement relating to our 2015 annual meeting of stockholders.

PART IV

Item 15. *Exhibits, Financial Statement Schedules.*

(a) Index to Consolidated Financial Statements, Financial Statement Schedules and Exhibits:

(1) ***Consolidated Financial Statements:***

The consolidated financial statements required to be included in Part II, Item 8, *Financial Statements and Supplementary Data*, begin on Page F-1 and are submitted as a separate section of this report.

(2) ***Consolidated Financial Statement Schedules:***

All schedules are omitted because they are not applicable or not required, or because the required information is included in the consolidated financial statements or notes in this report.

(3) ***Exhibits:***

Exhibit Number		Description of Exhibits
3.1	—	Amended and Restated Certificate of Incorporation (incorporated by reference from exhibits to the Registration Statement on Form S-8 filed by LifePoint Hospitals, Inc. on April 19, 2005, File No. 333-124151).
3.2	—	Fifth Amended and Restated By-Laws of LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 17, 2014, File No. 000-51251).
4.1	—	Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929).
4.2	—	Amended and Restated Rights Agreement, dated February 25, 2009, by and between LifePoint Hospitals, Inc. and American Stock Transfer & Trust Company, LLC (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated February 25, 2009, File No. 000-51251).
4.3	—	Indenture, dated May 29, 2007, by and between LifePoint Hospitals, Inc. as Issuer and The Bank of New York Trust Company, N.A., as Trustee (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 31, 2007, File No. 000-51251).
4.4	—	Indenture, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 6.625% Senior Notes due 2020) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 27, 2010, File No. 000-51251).
4.5	—	Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 5.5% Senior Note due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 9, 2013, File No. 000-51251).
4.6	—	Registration Rights Agreement, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 27, 2010, File No. 000-51251).

Exhibit Number		Description of Exhibits
4.7	—	Registration Rights Agreement, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 9, 2013, File No. 000-51251).
4.8	—	Registration Rights Agreement, dated as of May 12, 2014, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 13, 2014, File No. 000-51251).
10.1	—	Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 21, 2008, File No. 000-51251).
10.2	—	Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA — Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).
10.3	—	LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*
10.4	—	Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.5	—	LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).*
10.6	—	First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*
10.7	—	Amendment No. 2 to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed June 6, 2014, File No. 000-51251).*
10.8	—	Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.9	—	LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 16, 2008, File No. 000-51251).*

Exhibit Number		Description of Exhibits
10.10	—	LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).*
10.11	—	Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).*
10.12	—	Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).*
10.13	—	LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*
10.14	—	Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.15	—	LifePoint Hospitals Deferred Compensation Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 15, 2009, File No. 000-51251).*
10.16	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated December 22, 2010 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*
10.17	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated March 14, 2011 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*
10.18	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated November 24, 2014 (filed herewith).*
10.19	—	Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents, and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Barclays Bank PLC, as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).

Exhibit Number		Description of Exhibits
10.20	—	Incremental Facility Amendment No. 1, dated as of February 6, 2013, by and among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A., as administrative agent, and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as leads arrangers, to the Credit Agreement, dated as of July 24, 2012, among Borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated February 7, 2013, File No. 000-51251).
10.21	—	Credit Agreement Amendment No. 2, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc., the lenders party thereto, Citibank, N.A., as administrative agent and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC, as lead arrangers, to that certain Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., the lenders party thereto, the Administrative Agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners, as amended by Incremental Facility Amendment No. 1 dated as of February 6, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 26, 2013, File No. 000-51251).
10.22	—	Executive Severance and Restrictive Covenant Agreement, dated December 11, 2008, by and between LifePoint CSGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*
10.23	—	First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 17, 2012, File No. 000-51251).*
10.24	—	Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 20, 2008, File No. 000-51251).*
10.25	—	LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from Appendix A to the LifePoint Hospitals, Inc. Proxy Statement filed April 24, 2013, File No. 000-51251).*
10.26	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (Performance-Based Vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.27	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.28	—	Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement for the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*

Exhibit Number		Description of Exhibits
10.29	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement for non-employee directors (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, File No. 000-51251).*
10.30	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.31	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.32	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.33	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.34	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (filed herewith).*
10.35	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Non-Qualified Stock Option Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.36	—	Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).*
10.37	—	Voluntary Resignation Agreement and General Release by and between Jeffrey S. Sherman and HSGCP, LLC, dated September 4, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 6, 2013, File No. 000-51251).*
12.1	—	Ratio of Earnings to Fixed Charges
21.1	—	List of Subsidiaries
23.1	—	Consent of Independent Registered Public Accounting Firm
31.1	—	Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	—	Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002
32.1	—	Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	—	Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002
101.INS	—	XBRL Instance Document**
101.SCH	—	XBRL Taxonomy Extension Schema Document**
101.CAL	—	XBRL Taxonomy Calculation Linkbase Document**

Exhibit Number		Description of Exhibits
101.DEF	—	XBRL Taxonomy Definition Linkbase Document**
101.LAB	—	XBRL Taxonomy Label Linkbase Document**
101.PRE	—	XBRL Taxonomy Presentation Linkbase Document**

* — Management Compensation Plan or Arrangement

** — Furnished electronically herewith

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Management's Report on Internal Control Over Financial Reporting

Management of LifePoint Hospitals, Inc. is responsible for the preparation, integrity and fair presentation of its published consolidated financial statements. The financial statements have been prepared in accordance with U.S. generally accepted accounting principles and, as such, include amounts based on judgments and estimates made by management. The Company also prepared the other information included in the annual report and is responsible for its accuracy and consistency with the consolidated financial statements.

Management is also responsible for establishing and maintaining effective internal control over financial reporting. The Company's internal control over financial reporting includes those policies and procedures that pertain to the Company's ability to record, process, summarize and report reliable financial data. The Company maintains a system of internal control over financial reporting, which is designed to provide reasonable assurance to the Company's management and Board of Directors regarding the preparation of reliable published financial statements and safeguarding of the Company's assets. The system includes a documented organizational structure and division of responsibility, established policies and procedures, including a code of conduct to foster a strong ethical climate, which are communicated throughout the Company, and the careful selection, training and development of our people.

The Board of Directors, acting through its Audit and Compliance Committee, is responsible for the oversight of the Company's accounting policies, financial reporting and internal control. The Audit and Compliance Committee of the Board of Directors is comprised entirely of outside directors who are independent of management. The Audit and Compliance Committee is responsible for the appointment and compensation of the independent registered public accounting firm. It meets periodically with management, the independent registered public accounting firm and the internal auditors to ensure that they are carrying out their responsibilities. The Audit and Compliance Committee is also responsible for performing an oversight role by reviewing and monitoring the financial, accounting and auditing procedures of the Company in addition to reviewing the Company's financial reports. Internal auditors monitor the operation of the internal control system and report findings and recommendations to management and the Audit and Compliance Committee. Corrective actions are taken to address control deficiencies and other opportunities for improving the internal control system as they are identified. The independent registered public accounting firm and the internal auditors have full and unlimited access to the Audit and Compliance Committee, with or without management, to discuss the adequacy of internal control over financial reporting, and any other matters which they believe should be brought to the attention of the Audit and Compliance Committee.

Management recognizes that there are inherent limitations in the effectiveness of any system of internal control over financial reporting, including the possibility of human error and the circumvention or overriding of internal control. Accordingly, even effective internal control over financial reporting can provide only reasonable assurance with respect to financial statement preparation and may not prevent or detect misstatements. Further, because of changes in conditions, the effectiveness of internal control over financial reporting may vary over time.

The Company assessed its internal control system as of December 31, 2014 in relation to criteria for effective internal control over financial reporting described in "Internal Control — Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). Based on its assessment, the Company has determined that, as of December 31, 2014, its system of internal control over financial reporting was effective.

The Company acquired eight hospitals during the year ended December 31, 2014. The Company excluded all eight of these hospitals from its assessment of and conclusion on the effectiveness of its internal control over financial reporting. For the year ended December 31, 2014, these hospitals contributed approximately $416.3 million, or 9.3%, of the Company's total revenues and, as of December 31, 2014, accounted for approximately $471.6 million or 8.6%, of its total assets.

The consolidated financial statements have been audited by the independent registered public accounting firm of Ernst & Young LLP, which was given unrestricted access to all financial records and related data, including minutes of all meetings of stockholders, the Board of Directors and committees of the Board. Reports of the independent registered public accounting firm, which includes the independent registered public accounting firm's attestation report on the Company's internal control over financial reporting, are also presented within this document.

/s/ William F. Carpenter III	/s/ Leif M. Murphy
Chief Executive Officer and Chairman of the Board of Directors	Executive Vice President and Chief Financial Officer

Brentwood, Tennessee
February 12, 2015

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of LifePoint Hospitals, Inc.

We have audited LifePoint Hospitals, Inc.'s (the "Company") internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Wilson Medical Center, Rutherford Regional Medical Center, Haywood Regional Medical Center, Harris Regional Hospital, Swain County Hospital, Conemaugh Memorial Medical Center, Meyersdale Medical Center and Miners Medical Center, which are included in the 2014 consolidated financial statements of LifePoint Hospitals, Inc. and constituted \$471.6 million and \$267.1 million of total and net assets, respectively, as of December 31, 2014 and \$416.3 million and \$3.3 million of revenues and net income attributable to LifePoint Hospitals, Inc., respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Wilson Medical Center, Rutherford Regional Medical Center, Haywood Regional Medical Center, Harris Regional Hospital, Swain County Hospital, Conemaugh Memorial Medical Center, Meyersdale Medical Center and Miners Medical Center.

In our opinion, LifePoint Hospitals, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of LifePoint Hospitals, Inc. as of December 31, 2014 and 2013 and the related consolidated statements of operations, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2014 of LifePoint Hospitals, Inc. and our report dated February 12, 2015 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 12, 2015

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of LifePoint Hospitals, Inc.

We have audited the accompanying consolidated balance sheets of LifePoint Hospitals, Inc. (the "Company") as of December 31, 2014 and 2013, and the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2014. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Hospitals, Inc. at December 31, 2014 and 2013, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2014, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), LifePoint Hospitals, Inc.'s internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) and our report dated February 12, 2015 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 12, 2015

LIFEPOINT HOSPITALS, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS
For the Years Ended December 31, 2014, 2013 and 2012
(In millions, except per share amounts)

	2014	2013	2012
Revenues before provision for doubtful accounts	$ 5,300.9	$ 4,428.7	$ 4,016.2
Provision for doubtful accounts	817.8	750.4	624.4
Revenues	4,483.1	3,678.3	3,391.8
Salaries and benefits	2,134.5	1,727.4	1,554.5
Supplies	699.0	577.1	524.6
Other operating expenses	1,087.3	900.9	799.1
Other income	(71.9)	(64.1)	(32.0)
Depreciation and amortization	250.5	228.2	193.1
Interest expense, net	123.0	97.0	100.0
Impairment charges	57.7	—	4.0
Debt transaction costs	—	5.9	4.4
Gain on settlement of pre-acquisition contingent obligation	—	(5.6)	—
	4,280.1	3,466.8	3,147.7
Income from continuing operations before income taxes	203.0	211.5	244.1
Provision for income taxes	68.1	79.3	88.5
Income from continuing operations	134.9	132.2	155.6
Income from discontinued operations, net of income taxes	—	0.4	—
Net income	134.9	132.6	155.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.8)	(4.4)	(3.7)
Net income attributable to LifePoint Hospitals, Inc.	$ 126.1	$ 128.2	$ 151.9
Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:			
Continuing operations	$ 2.81	$ 2.76	$ 3.22
Discontinued operations	—	0.01	—
Net income	$ 2.81	$ 2.77	$ 3.22
Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:			
Continuing operations	$ 2.69	$ 2.68	$ 3.14
Discontinued operations	—	0.01	—
Net income	$ 2.69	$ 2.69	$ 3.14
Weighted average shares and dilutive securities outstanding:			
Basic	44.9	46.3	47.2
Diluted	46.9	47.6	48.4
Amounts attributable to LifePoint Hospitals, Inc. stockholders:			
Income from continuing operations, net of income taxes	$ 126.1	$ 127.8	$ 151.9
Income from discontinued operations, net of income taxes	—	0.4	—
Net income	$ 126.1	$ 128.2	$ 151.9

LIFEPOINT HOSPITALS, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
For the Years Ended December 31, 2014, 2013 and 2012
(In millions)

	2014	2013	2012
Net income	$ 134.9	$ 132.6	$ 155.6
Other comprehensive (loss) income, net of income taxes:			
Unrealized (loss) gain on changes in funded status of pension benefit obligations, net of benefit (provision) for income taxes of $4.2 and ($1.9) for the years ended December 31, 2014 and 2013, respectively	(7.8)	3.2	0.2
Other comprehensive (loss) income	(7.8)	3.2	0.2
Comprehensive income	127.1	135.8	155.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.8)	(4.4)	(3.7)
Comprehensive income attributable to LifePoint Hospitals, Inc.	$ 118.3	$ 131.4	$ 152.1

LIFEPOINT HOSPITALS, INC.

CONSOLIDATED BALANCE SHEETS
For the Years Ended December 31, 2014 and 2013
(In millions)

	2014	2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 191.5	$ 637.9
Accounts receivable, less allowances for doubtful accounts of $709.5 and $741.2 at December 31, 2014 and 2013, respectively	752.6	595.7
Inventories	115.2	102.0
Prepaid expenses	45.4	38.0
Income taxes receivable	33.0	—
Deferred tax assets	72.8	147.7
Other current assets	85.7	72.9
	1,296.2	1,594.2
Property and equipment:		
Land	134.8	112.3
Buildings and improvements	2,155.9	2,019.6
Equipment	1,633.8	1,469.9
Construction in progress (estimated costs to complete and equip after December 31, 2014 is $66.1)	72.9	58.7
	3,997.4	3,660.5
Accumulated depreciation	(1,619.9)	(1,463.3)
	2,377.5	2,197.2
Deferred loan costs, net	31.7	31.1
Intangible assets, net	69.1	72.6
Other assets	46.4	40.7
Goodwill	1,636.1	1,651.0
Total assets	$ 5,457.0	$ 5,586.8
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 158.5	$ 135.9
Accrued salaries	202.4	139.6
Other current liabilities	203.2	197.2
Current maturities of long-term debt	19.2	583.0
	583.3	1,055.7
Long-term debt	2,199.3	1,793.8
Deferred income tax liabilities	187.5	233.1
Long-term portion of reserves for self-insurance claims	133.2	139.8
Other long-term liabilities	84.7	72.0
Total liabilities	3,188.0	3,294.4
Redeemable noncontrolling interests	87.1	59.8
Equity:		
LifePoint Hospitals, Inc. stockholders' equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued	—	—
Common stock, $0.01 par value; 90,000,000 shares authorized; 66,245,310 and 65,548,140 shares issued at December 31, 2014 and 2013, respectively	0.7	0.7
Capital in excess of par value	1,496.2	1,470.7
Accumulated other comprehensive (loss) income	(4.4)	3.4
Retained earnings	1,473.1	1,347.0
Common stock in treasury, at cost, 21,672,250 and 18,404,586 shares at December 31, 2014 and 2013, respectively	(811.0)	(611.7)
Total LifePoint Hospitals, Inc. stockholders' equity	2,154.6	2,210.1
Noncontrolling interests	27.3	22.5
Total equity	2,181.9	2,232.6
Total liabilities and equity	$ 5,457.0	$ 5,586.8

LIFEPOINT HOSPITALS, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 2014, 2013 and 2012
(In millions)

	2014	2013	2012
Cash flows from operating activities:			
Net income	$ 134.9	$ 132.6	$ 155.6
Adjustments to reconcile net income to net cash provided by operating activities:			
Income from discontinued operations	—	(0.4)	—
Stock-based compensation	27.3	25.4	27.4
Depreciation and amortization	250.5	228.2	193.1
Amortization of physician minimum revenue guarantees	14.7	17.2	19.6
Amortization of debt discounts, premium and deferred loan costs	14.0	26.9	31.4
Impairment charges	57.7	—	4.0
Debt transaction costs	—	5.9	4.4
Gain on settlement of pre-acquisition contingent obligation	—	(5.6)	—
Deferred income taxes (benefit)	22.8	(20.4)	(24.2)
Reserve for self-insurance claims, net of payments	11.7	3.3	1.6
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures:			
Accounts receivable	(54.3)	(27.0)	(43.3)
Inventories, prepaid expenses and other current assets	(18.6)	(17.1)	(9.7)
Accounts payable, accrued salaries and other current liabilities	(14.4)	(16.3)	19.5
Income taxes payable/receivable	(35.5)	1.8	2.3
Other	1.5	(0.4)	1.2
Net cash provided by operating activities – continuing operations	412.3	354.1	382.9
Net cash used in operating activities – discontinued operations	—	(0.1)	(0.7)
Net cash provided by operating activities	412.3	354.0	382.2
Cash flows from investing activities:			
Purchases of property and equipment	(207.1)	(185.2)	(221.4)
Acquisitions, net of cash acquired	(265.6)	(188.1)	(199.7)
Other	(0.5)	1.0	(1.0)
Net cash used in investing activities	(473.2)	(372.3)	(422.1)
Cash flows from financing activities:			
Proceeds from borrowings	412.0	1,053.0	555.0
Payments of borrowings	(585.4)	(453.7)	(469.3)
Repurchases of common stock	(222.3)	(39.1)	(95.5)
Payments of debt financing costs	(7.2)	(20.0)	(10.0)
Proceeds from exercise of stock options	23.9	39.2	21.8
Other	(6.5)	(8.2)	(3.3)
Net cash (used in) provided by financing activities	(385.5)	571.2	(1.3)
Change in cash and cash equivalents	(446.4)	552.9	(41.2)
Cash and cash equivalents at beginning of period	637.9	85.0	126.2
Cash and cash equivalents at end of period	$ 191.5	$ 637.9	$ 85.0
Supplemental disclosure of cash flow information:			
Interest payments	$ 112.8	$ 68.6	$ 70.0
Capitalized interest	$ 1.0	$ 1.4	$ 2.3
Income tax payments, net	$ 80.9	$ 98.2	$ 110.5

LIFEPOINT HOSPITALS, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2014, 2013 and 2012
(In millions)

	LifePoint Hospitals, Inc. Stockholders							
	Common Stock							
	Shares	Amount	Capital in Excess of Par Value	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Noncontrolling Interests	Total
Balance at January 1, 2012	48.3	$ 0.6	$1,354.8	$ —	$1,066.9	$(477.1)	$ 14.4	$1,959.6
Net income	—	—	—	—	151.9	—	3.7	155.6
Other comprehensive income	—	—	—	0.2	—	—	—	0.2
Exercise of stock options and tax benefits of stock-based awards	0.7	—	25.3	—	—	—	—	25.3
Stock activity in connection with employee stock purchase plan	—	—	1.2	—	—	—	—	1.2
Stock-based compensation	0.5	—	27.4	—	—	—	—	27.4
Repurchases of common stock, at cost	(2.6)	—	—	—	—	(95.5)	—	(95.5)
Noncash change in noncontrolling interests as a result of acquisition and other	—	—	(5.2)	—	—	—	8.3	3.1
Cash distributions to noncontrolling interests	—	—	—	—	—	—	(3.8)	(3.8)
Balance at December 31, 2012	46.9	0.6	1,403.5	0.2	1,218.8	(572.6)	22.6	2,073.1
Net income	—	—	—	—	128.2	—	4.4	132.6
Other comprehensive income	—	—	—	3.2	—	—	—	3.2
Exercise of stock options and tax benefits of stock-based awards	1.1	0.1	42.2	—	—	—	—	42.3
Stock activity in connection with employee stock purchase plan	—	—	(0.4)	—	—	—	—	(0.4)
Stock-based compensation	—	—	25.4	—	—	—	—	25.4
Repurchases of common stock, at cost	(0.9)	—	—	—	—	(39.1)	—	(39.1)
Noncash change in noncontrolling interests as a result of acquisition and other	—	—	—	—	—	—	1.0	1.0
Cash distributions to noncontrolling interests	—	—	—	—	—	—	(5.5)	(5.5)
Balance at December 31, 2013	47.1	0.7	1,470.7	3.4	1,347.0	(611.7)	22.5	2,232.6
Net income	—	—	—	—	126.1	—	2.3	128.4
Other comprehensive loss	—	—	—	(7.8)	—	—	—	(7.8)
Exercise of stock options, tax benefits of stock-based awards and other	0.8	—	28.2	—	—	—	—	28.2
Stock activity in connection with employee stock purchase plan	—	—	(0.2)	—	—	—	—	(0.2)
Stock-based compensation	—	—	27.3	—	—	—	—	27.3
Repurchases of common stock, at cost	(3.9)	—	—	—	—	(222.3)	—	(222.3)
Conversion of 3½% Notes	0.6	—	(22.1)	—	—	23.0	—	0.9
Noncash change in noncontrolling interests as a result of acquisition and other	—	—	(7.7)	—	—	—	4.4	(3.3)
Cash distributions to noncontrolling interests	—	—	—	—	—	—	(1.9)	(1.9)
Balance at December 31, 2014	44.6	$ 0.7	$1,496.2	$ (4.4)	$1,473.1	$(811.0)	$ 27.3	$2,181.9

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Hospitals, Inc., a Delaware corporation, acting through its subsidiaries, operates general acute care hospitals primarily in non-urban communities in the United States ("U.S."). Unless the context otherwise indicates, LifePoint Hospitals, Inc. and its subsidiaries are referred to herein as "LifePoint" or the "Company." At December 31, 2014, on a consolidated basis, the Company operated 67 hospital campuses in 21 states. Effective January 1, 2015, the Company sold Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville") located throughout northwest Alabama. Upon completion of this sale, the Company operated 64 hospital campuses in 21 states, having a total of 8,024 licensed beds. Unless noted otherwise, discussions in these notes pertain to the Company's continuing operations, which exclude the results of those facilities that have previously been disposed prior to the adoption of Accounting Standards Update ("ASU") No. 2014-8, "Presentation of Financial Statements and Property, Plant, and Equipment — Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-8").

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner or controlling member of such entities. Additionally, the Company consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation.

In connection with certain acquisitions, the Company has entered into agreements to provide management and administrative support for the operations of six hospitals. The Company has concluded that these hospitals qualify as variable interest entities in accordance with Accounting Standards Codification ("ASC") 810-10 "Consolidations" and, due to its economic interest in these hospitals combined with its agreements to provide management and administrative support, it is the primary beneficiary. Accordingly, the Company has consolidated the operations of these six hospitals.

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, in accordance with the equity method of accounting. The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the Company's accompanying consolidated financial statements and notes to consolidated financial statements. Actual results could differ from those estimates.

Discontinued Operations

In accordance with the provisions of ASC 360-10, "Property, Plant and Equipment", ("ASC 360-10"), the Company has presented the operating results and cash flows of its previously disposed facilities as discontinued operations, net of income taxes, in the accompanying consolidated financial statements.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

In April 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-8. Among other provisions and in addition to expanded disclosures, ASU 2014-8 changes the definition of what components of an entity qualify for discontinued operations treatment and reporting from a reportable segment, operating segment, reporting unit, subsidiary or asset group to only those components of an entity that represent a strategic shift that has, or will have, a major effect on an entity's operations and financial results. Additionally, ASU 2014-8 requires disclosure about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements, including the pretax profit or loss, attributable to the component of an entity for the period in which it is disposed of or is classified as held for sale. The disclosure of this information is required for all of the same periods that are presented in the entity's results of operations for the period. The Company adopted the provisions of ASU 2014-8 during the year ended December 31, 2014.

As more fully discussed in Note 3, during the year ended December 31, 2014, the Company sold certain assets of River Parishes Hospital ("River Parishes"), located in LaPlace, Louisiana. Additionally, effective January 1, 2015, and again as more fully discussed in Note 3, the Company sold almost all of the assets of Lakeland, Northwest and Russellville. The Company has determined that none of the aforementioned disposals qualify for discontinued operations treatment in accordance with the provisions of ASU 2014-8. However, the Company has provided the additional required disclosures.

General and Administrative Costs

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include its hospital support center overhead costs, which were $223.4 million, $182.1 million and $173.6 million for the years ended December 31, 2014, 2013 and 2012, respectively. Included in the Company's hospital support center overhead costs are depreciation and amortization expenses related primarily to the Company's information systems platforms of $29.5 million, $27.0 million and $16.2 million for the years ended December 31, 2014, 2013 and 2012, respectively. Additionally, included in the Company's hospital support center overhead costs are transactional expenses related to the Company's recent acquisitions, including legal and consulting fees, which were $12.4 million, $6.0 million and $10.1 million for the years ended December 31, 2014, 2013 and 2012, respectively. See Note 2 for a further discussion of the Company's recent acquisition activity.

Fair Value of Financial Instruments

In accordance with ASC 825-10, "Financial Instruments", the fair value of the Company's financial instruments are further described as follows.

Cash and Cash Equivalents, Accounts Receivable and Accounts Payable

The carrying amounts reported in the accompanying consolidated balance sheets for cash and cash equivalents, accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

Long-Term Debt

The carrying amounts and fair values of the Company's senior secured term loan facility (the "Term Facility") and senior secured incremental term loans (the "Incremental Term Loans") under its senior secured credit agreement with, among others, Citibank, N.A. ("Citibank"), as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes") and 3½% convertible senior subordinated notes due May 15, 2014 (the "3½% Notes") as of December 31, 2014 and December 31, 2013 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2014	December 31, 2013	December 31, 2014	December 31, 2013
Senior Credit Agreement:				
Term Facility	$ 421.9	$ 433.1	$ 420.3	$ 434.2
Incremental Term Loans, excluding unamortized discount	$ 222.6	$ 222.6	$ 222.0	$ 224.2
6.625% Senior Notes	$ 400.0	$ 400.0	$ 422.0	$ 425.0
5.5% Senior Notes, excluding unamortized premium	$ 1,100.0	$ 700.0	$ 1,130.3	$ 703.5
3½% Notes, excluding unamortized discount	$ —	$ 575.0	$ —	$ 622.4

The fair values of the Term Facility, the Incremental Term Loans, the 6.625% Senior Notes and the 5.5% Senior Notes were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, "Fair Value Measurements and Disclosures" ("ASC 820-10"). The fair values of the 3½% Notes were estimated based on the quoted market prices determined using the closing share price of the Company's common stock and categorized as Level 1 within the fair value hierarchy in accordance with ASC 820-10. As more fully discussed in Note 5, effective May 12, 2014, the Company issued $400.0 million of additional 5.5% Senior Notes at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million. The net proceeds from this additional issuance were used to fund, in part, the cash-settled portion of the maturity or conversion of the 3½% Notes on or before May 15, 2014.

Common Stock Warrant

As more fully discussed Note 2 and Note 8, as partial consideration in connection with the Company's acquisition of Conemaugh Health System, the Company issued a warrant to the seller. The warrant, classified as a liability, is marked-to-market using an option pricing model which considers the warrant's contractual term, a combination of both historical volatility and implied volatility from traded options of the Company's common stock, risk-free interest rates and dividend assumptions. Since all significant inputs are market-based and observable, the warrant is categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10. At December 31, 2014, the fair value of the warrant was $9.2 million and is included in the Company's consolidated balance sheets under the caption "Other long-term liabilities".

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers are generally less than the Company's established billing rates.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

Additionally, to provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Accordingly, the revenues and accounts receivable reported in the Company's consolidated financial statements are recorded at the net amount expected to be received.

On April 5, 2012, a settlement agreement (the "Rural Floor Settlement") was signed between the Department of Health and Human Services ("HHS"), the Secretary of HHS, Centers for Medicare and Medicaid Services ("CMS") and a large number of healthcare service providers, including the Company's hospitals. The Rural Floor Settlement resolved all claims related to CMS's calculation of the rural floor budget neutrality adjustment that was created by the Balanced Budget Act of 1997 from federal fiscal year 1998 through and including federal fiscal year 2011 for healthcare service providers that participated in certain court cases and group appeals. As a result of the Rural Floor Settlement, the Company recognized $33.0 million of additional Medicare revenue during the year ended December 31, 2012.

The Company's revenues by payor and approximate percentages of revenues were as follows for the years ended December 31, 2014, 2013 and 2012 (in millions):

	2014		2013		2012	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Medicare	$1,361.4	30.4%	$1,199.5	32.6%	$1,170.3	34.5%
Medicaid	619.8	13.8	517.0	14.1	494.6	14.6
HMOs, PPOs and other private insurers	2,476.7	55.2	1,876.1	51.0	1,645.5	48.5
Self-pay	744.9	16.6	766.5	20.8	653.9	19.3
Other	98.1	2.2	69.6	1.9	51.9	1.5
Revenues before provision for doubtful accounts	5,300.9	118.2	4,428.7	120.4	4,016.2	118.4
Provision for doubtful accounts	(817.8)	(18.2)	(750.4)	(20.4)	(624.4)	(18.4)
Revenues	$4,483.1	100.0%	$3,678.3	100.0%	$3,391.8	100.0%

Contractual Discounts and Cost Report Settlements

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payors that receive discounts from its established billing rates. The Company must estimate the total amount of these discounts to prepare its consolidated financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Changes in estimates related to the allowance for contractual discounts affect revenues reported in the Company's accompanying consolidated statements of operations.

Cost report settlements under reimbursement agreements with Medicare and Medicaid are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated cost report settlements resulted in increases to revenues of approximately $2.5 million, $5.6 million and $7.0 million, increases to net income of approximately $1.6 million, $3.5 million and $4.4 million, and increases to diluted earnings per share of approximately $0.03, $0.07 and $0.09 for the years ended December 31, 2014, 2013 and 2012, respectively. The net cost report settlements due from the Company included as a current liability under the caption "Other current liabilities" in the accompanying consolidated balance sheets, were approximately $11.2 million and

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

$13.3 million at December 31, 2014 and 2013, respectively. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Company's gross charges. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2014, 2013 and 2012, the Company estimates that its costs of care provided under its charity care programs approximated $21.2 million, $35.2 million and $30.9 million, respectively. The decrease in the Company's estimated costs of charity care was primarily due to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of the Company's patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which the Company operates. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients.

The Company's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Company's gross charity care charges provided. The Company's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Company's local charity care policies. To the extent the Company receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Company does not include these patients' charges in its cost of care provided under its charity care program.

Provision and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients.

The Company has an established process to determine the adequacy of the allowance for doubtful accounts that relies on a number of analytical tools and benchmarks to arrive at a reasonable allowance. No single statistic or measurement determines the adequacy of the allowance for doubtful accounts. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payor classification and revenue days in accounts receivable. Accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

A summary of activity in the Company's allowance for doubtful accounts is as follows (in millions):

	Balances at Beginning of Year	Additions Recognized as a Reduction to Revenues	Accounts Written Off, Net of Recoveries	Balances at End of Year
Year ended December 31, 2014	$ 741.2	$ 817.8	$ (849.5)	$ 709.5
Year ended December 31, 2013	$ 558.4	$ 750.4	$ (567.6)	$ 741.2
Year ended December 31, 2012	$ 537.4	$ 624.4	$ (603.4)	$ 558.4

The allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts were 48.5% and 55.4% as of December 31, 2014 and 2013, respectively. The decrease in the resulting ratio of the allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, at December 31, 2014 as compared to December 31, 2013 is primarily the result of our recent acquisitions for which the Company recorded accounts receivable at its estimated fair value net of its estimate of an allowance for doubtful accounts, in addition to the write-off of aged and fully reserved accounts receivable during the year ended December 31, 2014. Additionally, as of December 31, 2014 and 2013, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 88.4% and 86.5%, respectively.

Concentration of Revenues

During the years ended December 31, 2014, 2013 and 2012, approximately 44.2%, 46.7% and 49.1%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payor that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues are particularly sensitive to regulatory and economic changes in certain states where the Company generates significant revenues. The following is an analysis by state of revenues as a percentage of the Company's total revenues for those states in which the Company generates significant revenues for the years ended December 31, 2014, 2013 and 2012:

	Hospital Campuses in State as of December 31, 2014	Revenue Concentration by State					
		2014		2013		2012	
		Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Virginia	6	$ 624.4	13.9%	$ 469.2	12.8%	$ 413.6	12.2%
Kentucky	9	587.9	13.1	520.9	14.2	510.9	15.1
Michigan	3	460.8	10.3	345.4	9.4	103.9	3.1
Tennessee	10	404.5	9.0	394.9	10.7	375.3	11.1
North Carolina	7	372.6	8.3	129.6	3.5	137.6	4.1
New Mexico	2	266.5	5.9	256.5	7.0	299.6	8.8
West Virginia	2	246.9	5.5	245.9	6.7	266.2	7.8
Arizona	2	222.8	5.0	214.7	5.8	204.4	6.0

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs, in the above-mentioned states or in Pennsylvania, where the Company anticipates Conemaugh Health System will generate significant revenues, could have an adverse effect on the Company's revenues or results of operations.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

Other Income

The American Recovery and Reinvestment Act of 2009 ("ARRA") provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified EHR technology. These provisions of ARRA, collectively referred to as the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), are intended to promote the adoption and meaningful use of interoperable health information technology and qualified EHR technology.

The Company accounts for EHR incentive payments in accordance with ASC 450-30, "Gain Contingencies" ("ASC 450-30"). In accordance with ASC 450-30, the Company recognizes a gain for EHR incentive payments when its eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. The demonstration of meaningful use is based on meeting a series of objectives and varies among hospitals and physician practices, between the Medicare and Medicaid programs and within the Medicaid program from state to state. Additionally, meeting the series of objectives in order to demonstrate meaningful use becomes progressively more stringent as its implementation is phased in through stages as outlined by CMS. EHR incentive payments are subject to audit and potential recoupment if it is determined that the Company's hospitals did not meet the applicable meaningful use standards required in connection with such incentive payments. Furthermore, EHR incentive payments are subject to retrospective adjustment because the cost report data upon which the payments are based are further subject to audit.

For the years ended December 31, 2014, 2013 and 2012, the Company recognized $71.9 million, $64.1 million and $32.0 million in EHR incentive payments, respectively, in accordance with the HITECH Act under the Medicare and Medicaid programs, collectively. These payments are reflected separately in the accompanying consolidated statement of operations under the caption "Other income". Amounts recognized as other income that the Company anticipates collecting in future periods, but that were uncollected as of the balance sheet date totaled approximately $36.8 million and $25.4 million as of December 31, 2014 and 2013, respectively, and are included in the accompanying consolidated balance sheets under the caption "Other current assets".

The Company incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Company's receipt or recognition as other income of the EHR incentive payments. As we complete our full implementation of certified EHR technology in accordance with all three phases of the program, our EHR incentive payments will decline and ultimately end.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand and marketable securities with original maturities of three months or less. The Company places its cash in financial institutions that are federally insured in limited amounts.

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market and are comprised of purchased items. These inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 1. Organization and Summary of Significant Accounting Policies – (continued)

Long-Lived Assets

Property and Equipment

Purchases of property and equipment are recorded at cost. Property and equipment acquired in connection with business combinations are recorded at estimated fair value in accordance with the acquisition method of accounting as prescribed in ASC 805-10, "Business Combinations" ("ASC 805-10"). Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Fully depreciated assets are retained in property and equipment accounts until they are disposed of. Allocated interest on funds used to pay for the construction or purchase of major capital additions is included in the cost of each capital addition.

Depreciation is calculated by applying the straight-line method over the estimated useful lives of buildings and improvements and equipment. Assets under capital and financing leases are generally amortized using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Capitalized internal-use software costs are amortized over their expected useful life, which is generally four years. Useful lives are as follows:

	Years
Buildings and improvements (including those under capital and financing leases)	10 – 40
Equipment	3 – 10
Equipment under capital leases	3 – 5

Depreciation expense was $247.6 million, $222.9 million and $187.1 million for the years ended December 31, 2014, 2013 and 2012, respectively. Amortization expense related to assets under capital and financing leases and capitalized internal-use software costs are included in depreciation expense.

As of December 31, 2014, the majority of the Company's assets under capital and financing leases are primarily comprised of prepaid capital leases. The Company's assets under capital and financing leases are set forth in the following table at December 31, 2014 and 2013 (in millions):

	2014	2013
Buildings and improvements	$ 287.2	$ 281.0
Equipment	45.8	37.7
	333.0	318.7
Accumulated amortization	(111.3)	(96.9)
	$ 221.7	$ 221.8

The Company evaluates its long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows, in accordance with ASC 360-10. Fair value estimates are derived from established market values of comparable assets or internal calculations of estimated future net cash flows. The Company's estimates of future cash flows are based on assumptions and projections it believes to be reasonable and supportable. The Company's assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix and changes in legislation and other payor payment patterns. These assumptions vary by type of facility.

During the year ended December 31, 2014 and as more fully discussed in Note 3, the Company recognized pre-tax impairment charges totaling approximately $57.7 million in connection with its disposal of River Parishes, effective November 1, 2014, as well as its disposals of Lakeland, Northwest and Russellville, effective January 1, 2015. A portion of these charges related to the write-down of property and equipment to

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Note 1. Organization and Summary of Significant Accounting Policies – (continued)

their estimated fair values. Additionally, the Company incurred a $4.0 million pre-tax impairment charge during the year ended December 31, 2012 primarily related to the write-off of certain capitalized information system costs which the Company determined were no longer a necessary component of its ongoing information technology strategy.

Deferred Loan Costs

The Company records deferred loan costs for expenditures related to acquiring or issuing new debt instruments as well as for amendments to its existing debt instruments. These expenditures include bank fees and premiums as well as attorney's and filing fees. The Company amortizes these deferred loan costs over the life of the respective debt instrument using the effective interest method.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805-10 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350-10, "Intangibles — Goodwill and Other" ("ASC 350-10"), goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based on a combination of the income approach, which estimates the fair value of the Company based on its future discounted cash flows, and the market approach, which estimates the fair value of the Company based on comparable market prices. During the years ended December 31, 2014, 2013 and 2012, the Company performed its annual impairment tests as of October 1 and did not incur an impairment charge.

The Company's intangible assets relate to contract-based physician minimum revenue guarantees; non-competition agreements; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees and non-competition agreements are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. The Company's goodwill and intangible assets are further described in Note 4.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. To the extent the Company establishes a valuation allowance or increases this allowance, the Company must include an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Income taxes are further described in Note 6.

Point of Life Indemnity, Ltd.

The Company operates, with approval from the Cayman Islands Monetary Authority, a captive insurance company under the name Point of Life Indemnity, Ltd. Through this wholly-owned subsidiary of the Company, the captive insurance company issues malpractice insurance policies to certain of the Company's

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Note 1. Organization and Summary of Significant Accounting Policies – (continued)

employed physicians in addition to providing property insurance deductible reimbursement for some types of property losses and workers' compensation deductible coverage. Fees charged to these employed physicians are eliminated in consolidation. Reserves for the Company's estimate of the related outstanding claims, including incurred but not reported losses, are actuarially determined and are included as a component of the Company's reserves for professional liability self-insurance claims, as further discussed in this note.

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding a self-insured retention level. The Company's self-insured retention level for professional liability claims is \$5.0 million per claim at December 31, 2014 with a \$5.0 million inner aggregate per claim. Additionally, the Company's self-insured retention level for workers' compensation claims is \$1.0 million per claim in all states in which it operates except for Wyoming. The Company participates in a state specific program in Wyoming for its workers' compensation claims arising in this state. The Company's self-insured retention levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance claims was approximately \$50.6 million, \$44.3 million and \$42.8 million for the years ended December 31, 2014, 2013 and 2012, respectively.

The Company's reserves for professional liability claims are based upon quarterly actuarial calculations. The Company's reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.50%, 1.55% and 1.80% at December 31, 2014, 2013 and 2012, respectively. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Accordingly, the Company's reserves for self-insured claims, comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period, include both a current and long-term component. The current portion of the Company's reserves for self-insured claims is included under the caption "Other current liabilities" and the long-term portion is included under the caption "Long-term portion of reserves for self-insurance claims" in the accompanying consolidated balance sheets.

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Note 1. Organization and Summary of Significant Accounting Policies – (continued)

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2014 and 2013 (in millions):

	2014	2013
Current portion	$ 44.3	$ 28.2
Long-term portion	133.2	139.8
	$ 177.5	$ 168.0

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2014, 2013 and 2012, the Company's related self-insured claims expense decreased by $5.1 million, $12.9 million and $9.1 million, which increased net income by approximately $3.3 million, $7.9 million and $5.8 million, or $0.07, $0.17 and $0.12 per diluted share, respectively.

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserves for self-insured medical benefits were $28.0 million and $18.9 million at December 31, 2014 and 2013, respectively, and are included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to a parent. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of equity and earnings on the portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company.

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2014 and 2013 (in millions):

Balance at January 1, 2013	$ 22.6
Net income attributable to noncontrolling interests	4.4
Acquisitions	1.0
Other	(5.5)
Balance at December 31, 2013	22.5
Net income attributable to noncontrolling interests	2.3
Acquisitions	8.3
Other	(5.8)
Balance at December 31, 2014	$ 27.3

Certain of the Company's noncontrolling interests include redemption features that cause these interests not to meet the requirements for classification as equity in accordance with ASC 480-10-S99-3, "Distinguishing Liabilities from Equity". Redemption of these interests features would require the delivery of

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 1. Organization and Summary of Significant Accounting Policies – (continued)

cash. Accordingly, these redeemable noncontrolling interests are classified in the mezzanine section of the Company's accompanying consolidated balance sheets under the caption "Redeemable noncontrolling interests". Changes in the fair value of the Company's redeemable noncontrolling interests are recognized as adjustments to consolidated stockholders' equity.

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2014 and 2013 (in millions):

Balance at January 1, 2013	$ 29.4
Acquisitions	29.9
Other	0.5
Balance at December 31, 2013	59.8
Net income attributable to redeemable noncontrolling interests	6.5
Acquisitions	19.6
Other	1.2
Balance at December 31, 2014	$ 87.1

Redemption features related to the Company's redeemable noncontrolling interests, if exercised, would require the Company to deliver cash in the following amounts for the years indicated (in millions):

2015	$ 47.9
2016	39.2
	$ 87.1

Segment Reporting

The Company has three operating groups as of December 31, 2014. The Company realigns these operating groups frequently based upon changing circumstances, including acquisition and divestiture activity. The Company considers these three operating groups as one operating segment, healthcare services, for segment reporting purposes and as one reporting unit for goodwill impairment testing in accordance with ASC 280-10, "Segment Reporting", ("ASC 280-10") and ASC 350-10.

In accordance with ASC 350-10, the Company has determined that its three operating groups and related acute care hospitals comprise one reporting unit because of their similar economic characteristics in each of the following areas:

- the way the Company manages its operations and extent to which its acquired facilities are integrated into its existing operations as a single reporting unit;
- the Company's goodwill is recoverable from the collective operations of its three operating groups and related acute care hospitals and not individually from one single operating group or hospital;
- its operating groups are frequently realigned based upon changing circumstances, including acquisition and divestiture activity; and
- because of the collective size of its three operating groups, each group and acute care hospital benefits from its participation in a group purchasing organization.

Stock-Based Compensation

The Company issues stock-based awards to key employees and directors under various stockholder-approved stock-based compensation plans, as further described in Note 9. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 "Compensation — Stock

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Note 1. Organization and Summary of Significant Accounting Policies – (continued)

Compensation", ("ASC 718-10"). In accordance with ASC 718-10, the Company recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value of each stock-based award.

Deferred Cash Awards

The Company grants deferred cash awards to certain employees that are subject to continuing service requirements and a ratable vesting term of three years. The Company recognizes compensation expense for these awards over their requisite service period. For the years ended December 31, 2014, 2013 and 2012, expense related to the Company's deferred cash awards was approximately $7.6 million, $7.0 million and $5.6 million, respectively. As of December 31, 2014, there was $9.8 million of total estimated unrecognized compensation costs related to deferred cash awards arrangements. The Company expects to recognize this cost over a weighted average period of 1.3 years.

Defined Contribution Plans

The Company maintains multiple defined contribution retirement plans that cover a majority of the Company's employees with a discretionary matching policy based on the Company's financial performance and definite contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $24.5 million, $11.1 million and $8.7 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Defined Benefit Pension Plans

In connection with its acquisition of Marquette General Health System ("Marquette General"), a 315 bed hospital system located in Marquette, Michigan effective September 1, 2012, through Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-owned controlled affiliate of Duke University Health Systems, Inc., the Company acquired certain assets and assumed certain liabilities associated with the benefits in the seller's defined benefit pension plan of certain employees covered by a collective bargaining agreement. The Company has established a separate defined benefit pension plan (the "Marquette Pension Plan"), to facilitate its administration of the assumed portion of the seller's defined benefit pension plan. In addition, in connection with its acquisition of Bell Hospital ("Bell"), a 25 bed critical access hospital located in Ishpeming, Michigan, effective December 1, 2013, the Company assumed sponsorship of Bell's defined benefit pension plan, which provides benefits to certain non-union employees (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans").

The Company accounts for its Pension Plans in accordance with ASC 715-30 "Compensation — Defined Benefit Plans", ("ASC 715-30"). In accordance with ASC 715-30, the Company recognizes the unfunded liability of its Pension Plans in the Company's consolidated balance sheet and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the Pension Plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality.

Earnings Per Share ("EPS")

EPS is based on the weighted average number of common shares outstanding and dilutive stock options, convertible notes, when dilutive, and nonvested shares. In addition, the numerator of EPS, net income, is adjusted for interest expense related to the Company's convertible notes, when dilutive, as more fully discussed in Note 5 and Note 12. The computation of the Company's basic and diluted EPS is set forth in Note 12.

LIFEPOINT HOSPITALS, INC.

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Note 1. Organization and Summary of Significant Accounting Policies – (continued)

Accounting Standards Not Yet Adopted

ASU No. 2014-9, "Revenue from Contracts with Customers"

In May 2014, the FASB issued ASU No. 2014-9, "Revenue from Contracts with Customers" ("ASU 2014-9"). ASU 2014-9 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

Among other provisions and in addition to expanded disclosure about the nature, amount, timing and uncertainty of revenue as well as certain additional quantitative and qualitative disclosures, ASU 2014-9 changes the healthcare industry specific presentation guidance under ASU 2011-7, "Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities." The provisions of ASU 2014-9 are effective for annual periods beginning after December 15, 2016, including interim periods within those years. Early adoption is not permitted. The Company is currently evaluating the impact that the adoption of ASU 2014-9 will have on its revenue recognition policies and procedures, financial position, result of operations, cash flows, financial disclosures and control framework.

Note 2. Acquisitions

2014 Acquisitions

Conemaugh Health System ("Conemaugh")

Effective September 1, 2014, through Duke LifePoint Healthcare, the Company acquired Conemaugh for total consideration, including net working capital, of approximately $125.0 million, comprised of $115.0 million in cash and the issuance of a warrant with an estimated fair value of $10.0 million. The warrant provides the seller rights to purchase 290,514 shares of the Company's common stock at an exercise price of $74.15 per share, exercisable ratably beginning one year from the date of issuance to three years after the date of issuance. The warrant expires ten years from the date of issuance. The warrant, classified as a liability and included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets, was valued using an option pricing model and will be marked-to-market until settlement.

Conemaugh is comprised of Conemaugh Memorial Medical Center, a 470 bed acute care hospital, 39 bed rehabilitation facility and 30 bed long-term care facility located in Johnstown, Pennsylvania, Meyersdale Medical Center, a 20 bed critical access hospital located in Meyersdale, Pennsylvania, and Miners Medical Center, a 30 bed acute care hospital located in Hastings, Pennsylvania. The Company has committed to invest in Conemaugh an additional $425.0 million in capital expenditures and improvements over the next ten years. The results of operations of Conemaugh are included in the Company's results of operations beginning on September 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Conemaugh have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis during 2015.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 2. Acquisitions – (continued)

Haywood Regional Medical Center ("Haywood")

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired Haywood, a 169 bed acute care hospital located in Clyde, North Carolina for approximately $28.5 million, including net working capital. The Company has committed to invest in Haywood an additional $36.0 million in capital expenditures and improvements over the next eight years. The results of operations of Haywood are included in the Company's results of operations beginning on August 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Haywood have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis during 2015.

WestCare Health System ("WestCare")

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired WestCare for approximately $19.0 million, including net working capital and the assumption of certain capital leases. WestCare is comprised of Harris Regional Hospital, an 86 bed acute care hospital located in Sylva, North Carolina, and Swain County Hospital, a 48 bed critical access hospital located in Bryson City, North Carolina. The Company has committed to invest in WestCare an additional $43.0 million in capital expenditures and improvements over the next eight years. The results of operations of WestCare are included in the Company's results of operations beginning on August 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of WestCare have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis during 2015.

Rutherford Regional Medical Center ("Rutherford")

Effective June 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Rutherford, a 143 bed acute care hospital located in Rutherfordton, North Carolina for approximately $27.2 million, including net working capital. The Company has committed to invest in Rutherford an additional $60.0 million in capital expenditures and improvements over the next ten years. The results of operations of Rutherford are included in the Company's results of operations beginning on June 1, 2014.

Wilson Medical Center ("Wilson")

Effective March 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Wilson, a 294 bed hospital and 90 bed long-term care facility located in Wilson, North Carolina for approximately $59.8 million, including net working capital. The Company has committed to invest in Wilson an additional $120.0 million in capital expenditures and improvements over the next ten years. The results of operations of Wilson are included in the Company's results of operations beginning on March 1, 2014. The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company's acquisition of Wilson have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the subsequent settlement for purchased working capital and final appraisals. The Company expects to finalize its analysis during 2015.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 2. Acquisitions – (continued)

2013 Acquisitions

Bell Hospital

Effective December 1, 2013, the Company acquired Bell for approximately $28.3 million, including net working capital, net of cash. The results of operations of Bell are included in the Company's results of operations beginning on December 1, 2013.

Portage Health ("Portage")

Effective December 1, 2013, the Company acquired an 80% interest in an entity that owns and operates Portage, a 36 bed hospital and 60 bed long-term care facility located in Hancock, Michigan for approximately $37.3 million, including 80% of the net working capital. The results of operations of Portage are included in the Company's results of operations beginning on December 1, 2013.

Fauquier Health ("Fauquier")

Effective November 1, 2013, the Company acquired an 80% interest in an entity that owns and operates Fauquier, a 97 bed hospital and 113 bed long-term care facility located in Warrenton, Virginia for approximately $103.7 million, including 80% of the net working capital. The results of operations of Fauquier are included in the Company's results of operations beginning on November 1, 2013.

Scott Memorial Hospital ("Scott Memorial")

In May 2012, the Company entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Healthcare Network of Kentucky and Southern Indiana ("RHN"), the purpose of which is to own and operate hospitals in non-urban communities in the Kentucky and Southern Indiana region. Effective January 1, 2013, RHN acquired Scott Memorial, a 25 bed critical access hospital located in Scottsburg, Indiana for approximately $9.5 million, including net working capital. The results of operations of Scott Memorial are included in the Company's results of operations beginning on January 1, 2013.

2012 Acquisitions

Marquette General

Effective September 1, 2012, the Company, through Duke LifePoint Healthcare, acquired Marquette General for approximately $132.7 million, including net working capital. The results of operations of Marquette General are included in the Company's results of operations beginning on September 1, 2012.

Woods Memorial Hospital ("Woods Memorial")

Effective July 1, 2012, the Company acquired Woods Memorial, a 72 bed hospital and an 88 bed long-term care facility located in Etowah, Tennessee for approximately $17.7 million, including net working capital. The results of operations of Woods Memorial are included in the Company's results of operations beginning on July 1, 2012.

Twin County Regional Hospital ("Twin County")

Effective April 1, 2012, the Company, through Duke LifePoint Healthcare, acquired an 80% interest in an entity that owns and operates Twin County, a 141 bed hospital located in Galax, Virginia for approximately $20.5 million, including 80% of the net working capital. The results of operations of Twin County are included in the Company's results of operations beginning April 1, 2012.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 2. Acquisitions – (continued)

Ancillary Service-Line Acquisitions

The Company completed certain ancillary service-line acquisitions, including physician practices, totaling $16.1 million, $18.8 million and $19.3 million during the years ended December 31, 2014, 2013 and 2012, respectively.

Note 3. Divestitures and Impairment Charges

Northwest Alabama Market

In November 2014, the Company entered into a definitive agreement to sell almost all of the assets of Lakeland, Northwest and Russellville. The sale closed effective January 1, 2015. Included in the Company's consolidated results of operations are net operating losses before income taxes attributable to these three facilities in the aggregate of $0.3 million and $6.8 million for the years ended December 31, 2014 and 2013, respectively, and net operating income before income taxes attributable to these three facilities in the aggregate of $0.7 million for the year ended December 31, 2012.

In connection with the Company's entry into a definitive agreement to sell certain assets of Lakeland, Northwest and Russellville and discontinue the hospitals' operations, the Company recognized impairment charges in the aggregate of $45.5 million, $28.1 million net of income taxes, or $0.60 loss per diluted share, during the year ended December 31, 2014. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

River Parishes

In September 2014, the Company entered into a definitive agreement to sell certain assets of River Parishes and discontinue its operation. The sale closed effective November 1, 2014. Included in the Company's consolidated results of operations are net operating losses before income taxes attributable to River Parishes of $4.0 million, $4.5 million and $1.4 million for the years ended December 31, 2014, 2013 and 2012, respectively.

In connection with the Company's entry into a definitive agreement to sell certain assets of River Parishes and discontinue its operation, the Company recognized an impairment charge of $12.2 million, $7.8 million net of income taxes, or $0.16 loss per diluted share, during the year ended December 31, 2014. The impairment charge includes the write-down of property, equipment and allocated goodwill to their estimated fair values.

Note 4. Goodwill and Intangible Assets

The following table presents the changes in the carrying amount of goodwill during the years ended December 31, 2014 and 2013 (in millions):

Balance at January 1, 2013	$ 1,611.8
Acquisitions	27.3
Adjustments related to prior year acquisitions	11.9
Balance at December 31, 2013	1,651.0
Acquisitions	10.2
Divestitures	(2.9)
Adjustments related to prior year acquisitions	(22.2)
Balance at December 31, 2014	$ 1,636.1

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 4. Goodwill and Intangible Assets – (continued)

The following table provides information regarding the Company's intangible assets, which are included in the accompanying consolidated balance sheets at December 31, 2014 and 2013 (in millions):

	2014	2013
Amortized intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 62.3	$ 73.4
Accumulated amortization	(35.5)	(39.4)
Net total	26.8	34.0
Non-competition agreements and other		
Gross carrying amount	23.6	24.5
Accumulated amortization	(15.9)	(14.1)
Net total	7.7	10.4
Total amortized intangible assets		
Gross carrying amount	85.9	97.9
Accumulated amortization	(51.4)	(53.5)
Net total	34.5	44.4
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	29.5	24.9
Licenses, provider numbers, accreditations and other	5.1	3.3
Net total	34.6	28.2
Total intangible assets:		
Gross carrying amount	120.5	126.1
Accumulated amortization	(51.4)	(53.5)
Net total	$ 69.1	$ 72.6

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460-10, "Guarantees" ("ASC 460-10"). In accordance with ASC 460-10, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2014 and 2013, the Company's liability for contract-based physician minimum revenue guarantees was $9.3 million and $11.5 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Non-Competition Agreements

The Company has entered into non-competition agreements with certain physicians and other individuals which are amortized on a straight-line basis over the term of the agreements.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 4. Goodwill and Intangible Assets – (continued)

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company operates hospitals in twelve states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

Licenses, Provider Numbers, Accreditations and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets, including physician minimum revenue guarantee expense in accordance with ASC 460-10, during the years ended December 31, 2014, 2013 and 2012 was $17.6 million, $22.5 million and $25.6 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years and thereafter are as follows (in millions):

2015	$ 13.2
2016	9.4
2017	5.4
2018	2.8
2019	1.3
Thereafter	2.4
	$ 34.5

Note 5. Long-Term Debt

The Company's long-term debt consists of the following at December 31, 2014 and 2013 (in millions):

	2014	2013
Senior Borrowings:		
Term Facility	$ 421.9	$ 433.1
Incremental Term Loans	222.6	222.6
6.625% Senior Notes	400.0	400.0
5.5% Senior Notes	1,100.0	700.0
Unamortized discount on Incremental Term Loans	(1.0)	(1.4)
Unamortized premium on 5.5% Senior Notes	10.9	—
	2,154.4	1,754.3
Subordinated Borrowings:		
3½% Notes	—	575.0
Unamortized discount on 3½% Notes	—	(8.1)
	—	566.9
Capital and financing leases	64.1	55.6
Total debt	$ 2,218.5	$ 2,376.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 5. Long-Term Debt – (continued)

Maturities of the Company's long-term debt at December 31, 2014, excluding an unamortized debt discount and premium and financing obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

2015	$ 19.2
2016	25.0
2017	606.9
2018	1.9
2019	2.1
Thereafter	1,526.6
	$ 2,181.7

Senior Credit Agreement

Terms

The Senior Credit Agreement, which was issued effective July 24, 2012 and matures on July 24, 2017, provides for the Term Facility, the Incremental Term Loans and a $350.0 million Revolving Facility. The Term Facility requires scheduled quarterly repayments in an amount equal to 2.5% per annum for each of the first, second and third years and 5.0% per annum for the fourth year and first three quarters of the fifth year, with the balance due at maturity. Additionally, the Term Facility and Incremental Term Loans are subject to mandatory prepayments based on excess cash flow, as well as upon the occurrence of certain other events, as specifically described in the Senior Credit Agreement. The Senior Credit Agreement is guaranteed on a senior basis by the Company's subsidiaries with certain limited exceptions.

Letters of Credit and Availability

The Revolving Facility may be utilized for letters of credit and swingline loans up to a maximum of $75.0 million and $25.0 million, respectively. Issued letters of credit and outstanding swingline loans reduce the amounts available for borrowing under the Revolving Facility. As of December 31, 2014, the Company had $22.4 million in letters of credit outstanding that were related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $327.6 million as of December 31, 2014.

The Senior Credit Agreement may, subject to certain conditions and to receipt of commitments from new or existing lenders, be increased up to a total of (i) $800.0 million and (ii) an amount such that, after giving pro forma effect to such increase and to the use of proceeds therefrom, the Company's secured leverage ratio does not exceed 3.50:1.00; provided that no lender is obligated to participate in any such increase.

Interest Rates

Interest on the outstanding borrowings under the Senior Credit Agreement is payable at the Company's option at either an adjusted London Interbank Offer Rate ("LIBOR") or an adjusted base rate plus an applicable margin. The applicable margin under the Senior Credit Agreement ranges from 1.50% to 2.50% for LIBOR loans and from 0.50% to 1.50% for adjusted base rate loans based on the Company's total leverage ratio, calculated in accordance with the Senior Credit Agreement.

As of December 31, 2014, the applicable annual interest rates under the Term Facility and the Incremental Term Loans were 2.17% and 2.67%, respectively, which were based on the 30-day adjusted LIBOR plus the applicable margins. The 30-day adjusted LIBOR was 0.17% for both the Term Facility and the Incremental Term Loans as of December 31, 2014.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 5. Long-Term Debt – (continued)

Covenants

The Senior Credit Agreement requires the Company to satisfy a maximum total leverage ratio calculated on a trailing four quarter basis not to exceed the following thresholds for the indicated date ranges:

Date Range	Maximum Total Leverage Ratio
July 1, 2014 to June 30, 2015	4.75:1.00
July 1, 2015 to June 30, 2016	4.50:1.00
July 1, 2016 to June 30, 2017	4.25:1.00

The Company was in compliance with this covenant as of December 31, 2014.

In addition, the Senior Credit Agreement contains certain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, merge, consolidate, enter into acquisitions, sell assets, effect sale leaseback transactions, pay dividends, pay subordinated debt and effect transactions with its affiliates. It does not contain provisions that would accelerate the maturity dates upon a downgrade in the Company's credit rating. However, a downgrade in the Company's credit rating could adversely affect its ability to obtain other capital sources in the future and could increase the Company's cost of borrowings.

6.625% Senior Notes

Effective September 23, 2010, the Company issued in a private placement $400.0 million of 6.625% unsecured senior notes due October 1, 2020 with The Bank of New York Mellon Trust Company, N.A., as trustee. The 6.625% Senior Notes bear interest at the rate of 6.625% per year, payable semi-annually on April 1 and October 1. The 6.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing and future subsidiaries that guarantee the Senior Credit Agreement.

The Company may redeem its 6.625% Senior Notes, in whole or in part, at any time prior to October 1, 2015 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem its 6.625% Senior Notes, in whole or in part, at any time on or after October 1, 2015, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

October 1, 2015 to September 30, 2016	103.313%
October 1, 2016 to September 30, 2017	102.208%
October 1, 2017 to September 30, 2018	101.104%
October 1, 2018 and thereafter	100.000%

If the Company experiences a change of control under certain circumstances, it must offer to repurchase all of the notes at a price equal to 101.000% of their principal amount, plus accrued and unpaid interest, if any, to the repurchase date.

The 6.625% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 5. Long-Term Debt – (continued)

5.5% Senior Notes

Effective December 6, 2013 and again on May 12, 2014, the Company issued in two separate private placements $700.0 million and $400.0 million, respectively, of the 5.5% Senior Notes with The Bank of New York Mellon Trust Company, N.A., as trustee. The $400.0 million of additional 5.5% Senior Notes issued on May 12, 2014 were issued at a premium of $12.0 million for total net proceeds from the issuance of $412.0 million which were used to fund, in part, the cash-settled portion of the maturity or conversion of the 3½% Notes on or before May 15, 2014. Collectively, the 5.5% Senior Notes mature on December 1, 2021 and bear interest at the rate of 5.5% per year, payable semi-annually on June 1 and December 1. The 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company's existing and future domestic subsidiaries.

The Company may redeem up to 35% of the aggregate principal amount of the 5.5% Senior Notes, at any time before December 1, 2016, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.500% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.5% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem the 5.5% Senior Notes, in whole or in part, at any time prior to December 1, 2016 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem the 5.5% Senior Notes, in whole or in part, at any time on or after December 1, 2016, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

December 1, 2016 to November 30, 2017	104.125%
December 1, 2017 to November 30, 2018	102.750%
December 1, 2018 to November 30, 2019	101.375%
December 1, 2019 and thereafter	100.000%

If the Company experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.5% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

3½% Notes

Effective May 15, 2014, the 3½% Notes matured. Prior to maturity, certain holders of the 3½% Notes exercised their right to convert per $1,000 in principal held for (i) an amount in cash, equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, the lesser of the daily conversion value for such volume-weighted average price trading day and $50; and (ii) a number of shares of the Company's common stock in an amount equal to the sum of, for each of the 20 volume-weighted average price trading days during the conversion period, any excess of the daily conversion value above $50. Upon maturity or conversion of the 3½% Notes, the Company delivered to the holders cash of approximately $574.2 million and approximately 0.6 million shares of its common stock previously held in treasury at an average historical cost basis of $35.86 per share, or $23.0 million.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 5. Long-Term Debt – (continued)

Debt Transaction Costs

During the year ended December 31, 2014, the Company capitalized $7.2 million of deferred loan costs in connection with the issuance of the $400.0 million of additional 5.5% Senior Notes. In connection with various debt transactions effected during the year ended December 31, 2013, including the Company's issuance of the 5.5% Senior Notes and its partial repayment of the Incremental Term Loans effective December 6, 2013, its amendments of the Senior Credit Agreement and the 6.625% Senior Notes pursuant to which it modified certain restrictive covenants regarding subsidiary guarantees effective August 23, 2013 and the issuance of the Incremental Term Loans effective February 6, 2013, the Company capitalized $19.3 million of deferred loan costs and incurred debt transaction costs totaling approximately $5.9 million. The debt transaction costs include the write-offs of previously capitalized deferred loan costs and new non-capital costs related to these transactions.

Unamortized Discounts on Convertible Debt

In accordance with ASC 470-20, "Debt with Conversion and Other Options" ("ASC 470-20"), the Company separately accounted for the liability and equity components of its convertible debt instruments in a manner that reflected the Company's nonconvertible debt borrowing rates for its 3½% Notes and its 3¼% Debentures at their fair values at their date of issuance. The resulting discounts were amortized as a component of interest expense over the expected lives of similar liabilities that do not have associated equity components, which for the Company's 3½% Notes and its 3¼% Debentures was its maturity date. The Company amortized the discount for its 3½% Notes through May 2014 at which point they matured. Additionally, the Company amortized the discount for its 3¼% Debentures through February 2013 at which point they were all repurchased with the proceeds from the issuance of the Incremental Term Loans.

The following table provides information regarding the principal balance, unamortized discount and net carrying balance of the Company's convertible debt instrument as of December 31, 2013 (in millions):

3½% Notes:	
Principal balance	$ 575.0
Unamortized discount	(8.1)
Net carrying balance	566.9

For the years ended December 31, 2014, 2013 and 2012, the contractual cash interest expense and non-cash interest expense (discount amortization) for the Company's convertible debt instruments were as follows (in millions):

	2014	2013	2012
3½% Notes:			
Contractual cash interest expense	$ 7.5	$ 20.1	$ 20.1
Non-cash interest expense (discount amortization)	8.1	20.5	19.1
Total interest expense	$ 15.6	$ 40.6	$ 39.2
3¼% Debentures:			
Contractual cash interest expense	$ —	$ 0.9	$ 7.3
Non-cash interest expense (discount amortization)	—	0.9	6.9
Total interest expense	$ —	$ 1.8	$ 14.2

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 5. Long-Term Debt – (continued)

Considering both the contractual cash interest expense and the non-cash amortization of the discounts for the 3½% Notes and 3¼% Debentures, the effective annual interest rates for the period the 3½% Notes were outstanding during the years ended December 31, 2014, 2013 and 2012 were 7.28%, 7.06% and 6.82%, respectively, and the effective annual interest rates for the period the 3¼% Debentures were outstanding during the years ended December 31, 2013 and 2012 were 6.50% and 6.31%, respectively.

Note 6. Income Taxes

The provision for income taxes for the years ended December 31, 2014, 2013 and 2012 consists of the following (in millions):

	2014	2013	2012
Current:			
Federal	$ 47.2	$ 94.0	$ 101.2
State	1.4	9.2	13.9
	48.6	103.2	115.1
Deferred:			
Federal	26.7	(24.5)	(20.7)
State	(4.8)	(5.0)	(7.0)
	21.9	(29.5)	(27.7)
Change in valuation allowance	(2.4)	5.6	1.1
Total	$ 68.1	$ 79.3	$ 88.5

The decrease in the valuation allowance during the year ended December 31, 2014 was primarily a result of the reversal of a valuation allowance established during the year ended December 31, 2013 against the Company's deferred tax assets for federal net operating losses generated by the Company's physician practice operations in the state of Michigan, which were previously thought to be unrecoverable. The impact of the reversal during the year ended December 31, 2014 resulted in an increase to net income of $6.0 million, or $0.13 per diluted share. Various subsidiaries have state net operating loss carry forwards in the aggregate of approximately $953.0 million (primarily in Alabama, Florida, Indiana, Louisiana, Pennsylvania, Tennessee, Virginia and West Virginia) with expiration dates through the year 2034.

The following is a reconciliation of the statutory federal income tax rate to the Company's effective income tax rate for income from continuing operations before income taxes and including net income from non-controlling interests for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
Federal statutory rate	35.0%	35.0%	35.0%
State income taxes, net of federal income tax benefits	1.0	2.1	1.8
Valuation allowances	(1.3)	2.9	0.6
Income tax liability reversals	(0.3)	(0.3)	(0.1)
Other items, net	0.7	(1.4)	(0.5)
Effective income tax rate	35.1%	38.3%	36.8%

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 6. Income Taxes – (continued)

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects are as follows as of December 31, 2014 and 2013 (in millions):

	2014	2013
Deferred income tax liabilities:		
Depreciation and amortization	$ (325.8)	$ (341.9)
Amortization of convertible debt discounts	—	(3.0)
Prepaid expenses	(2.7)	(1.5)
Other	(0.5)	(2.3)
Total deferred income tax liabilities	(329.0)	(348.7)
Deferred income tax assets:		
Provision for doubtful accounts	52.9	119.5
Employee compensation	89.9	69.9
Professional liability claims	53.9	46.4
Net operating losses and other	84.0	94.3
Total deferred income tax assets	280.7	330.1
Valuation allowance	(66.4)	(66.8)
Net deferred income tax assets	214.3	263.3
Net deferred income tax liabilities	$ (114.7)	$ (85.4)

The balance sheet classification of deferred income tax assets (liabilities) at December 31, 2014 and 2013 is as follows (in millions):

	2014	2013
Current	$ 72.8	$ 147.7
Long-term	(187.5)	(233.1)
Total	$ (114.7)	$ (85.4)

A reconciliation of the beginning and ending liability for gross unrecognized tax benefits at December 31, 2014 and 2013 is as follows (in millions):

	2014	2013
Balance at beginning of year	$ 15.0	$ 14.8
Additions for tax positions of prior years	2.4	2.3
Reductions for tax positions of prior years	(15.2)	(1.8)
Reductions for settlements with taxing authorities	(0.8)	—
Reductions for lapse of statutes of limitations	(0.3)	(0.3)
Balance at end of year	$ 1.1	$ 15.0

The components of the long-term income tax liability at December 31, 2014 and 2013 are as follows (in millions):

	2014	2013
Unrecognized tax benefits	$ 1.1	$ 15.0
Accrued interest and penalties	0.6	1.6
	$ 1.7	$ 16.6

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 6. Income Taxes – (continued)

Of the $1.1 million of unrecognized tax benefits at December 31, 2014, $0.9 million, if recognized, would affect the Company's effective tax rate. Included in the balance of unrecognized tax benefits at December 31, 2014 are tax positions of $0.2 million for which the ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. Because of the impact of deferred income tax accounting, other than for interest and penalties, the disallowance of the shorter deductibility period would not affect the effective income tax rate but would accelerate the payment of cash to the taxing authority to an earlier period.

The Company includes interest and penalties as a component of its income tax expense. During the year ended December 31, 2014, the Company recorded a net $0.6 million reduction of interest expense related to unrecognized tax benefits in income tax expense, which is comprised of an interest benefit of $1.0 million from the expiration of federal and state statutes of limitation, settlements with taxing authorities and interest expense of $0.4 million on unrecognized tax benefits from prior years.

The Company's U.S. Federal income tax returns for tax years 2011 and beyond remain subject to examination by the Internal Revenue Service. The expiration of the statutes of limitation related to the various state income tax returns that the Company and its subsidiaries file, varies by state. Generally, the Company's various state income tax returns for tax years 2008 and beyond remain subject to examination by various state taxing authorities. As a result of the expiration of the statutes of limitation for specific taxing jurisdictions, the Company's unrecognized tax positions could change within the next twelve months by a range of zero to $0.9 million.

Note 7. Other Current Liabilities

The following table provides information regarding the Company's other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2014 and 2013 (in millions):

	2014	2013
Current portion of reserves for self-insurance claims	$ 44.3	$ 28.2
EHR deferred income	—	25.6
Self-insured medical benefits liability	28.0	18.9
Estimated third party cost report settlements	11.2	13.3
Accrued interest	12.1	12.2
Physician minimum revenue guarantee liability	9.3	11.5
Other	98.3	87.5
	$ 203.2	$ 197.2

Note 8. Stockholders' Equity

Preferred Stock

The Company's Amended and Restated Certificate of Incorporation provides that up to 10,000,000 shares of preferred stock may be issued, of which 90,000 shares have been designated as Series A Junior Participating Preferred Stock, par value $0.01 per share ("Series A Preferred Stock"). The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders. Because the terms of the preferred stock may be fixed by the Board of Directors without stockholder action, the preferred stock could be issued quickly with terms calculated to defeat a proposed takeover or to make the removal of the Company's management more difficult.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 8. Stockholders' Equity – (continued)

Preferred Stock Purchase Rights

Pursuant to the Company's stockholders' rights plan, which was amended and restated on February 25, 2009, each outstanding share of common stock is accompanied by one preferred stock purchase right. Each right entitles the registered holder to purchase from the Company one one-thousandth of a share of Series A Preferred Stock of the Company at a price of $125 per one one-thousandth of a share, subject to adjustment. As of December 31, 2014, and 2013 there was no Series A Preferred Stock outstanding.

Each share of Series A Preferred Stock will be entitled, when, as and if declared, to a preferential quarterly dividend payment in an amount equal to the greater of $10 or 1,000 times the aggregate of all dividends declared per share of common stock. In the event of liquidation, dissolution or winding up, the holders of Series A Preferred Stock will be entitled to a minimum preferential liquidation payment equal to $1,000 per share, plus an amount equal to accrued and unpaid dividends and distributions on the stock, whether or not declared, to the date of such payment, but will be entitled to an aggregate payment of 1,000 times the payment made per share of common stock. The rights are not exercisable until the rights distribution date as defined in the stockholders' rights plan. The rights will expire on February 25, 2019, unless the expiration date is extended or unless the rights are earlier redeemed or exchanged.

The rights are designed to deter coercive takeover tactics and to prevent an acquirer from gaining control of the Company without offering a fair price to all of our stockholders. The Rights will not prevent a takeover, but are designed to encourage anyone seeking to acquire the Company to negotiate with its Board of Directors prior to attempting a takeover.

Common Stock

Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, the Senior Credit Agreement imposes restrictions on the Company's ability to pay dividends.

Common Stock in Treasury and Repurchases of Common Stock

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2011, as subsequently amended and extended in February 2013 (the "2011 Repurchase Plan") and a repurchase plan adopted in the first quarter of 2014 (the "2014 Repurchase Plan"). The 2011 Repurchase Plan provided for the repurchase of up to $350.0 million in shares of the Company's common stock, and the Company has repurchased all shares authorized for repurchase under this plan. The 2014 Repurchase Plan provides for the repurchase of up to $150.0 million in shares of the Company's common stock through October 1, 2015, although it is not obligated to repurchase any specific number of shares. The Company has designated the shares repurchased in accordance with its repurchase plans as treasury stock.

In connection with the 2014 Repurchase Plan, the Company has entered into a trading plan in accordance with SEC Rule 10b5-1 of the Exchange Act to facilitate repurchases of its common stock during its current black out period (the "10b5-1 Trading Plan"). The 10b5-1 Trading Plan became effective on December 17, 2014 and will expire on February 18, 2015.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 8. Stockholders' Equity – (continued)

The following tables summarize the Company's share repurchases in accordance with stock repurchase plans for the years ended December 31, 2014, 2013 and 2012 (in millions, except per share amounts):

	Year Ended December 31, 2014			Year Ended December 31, 2013			Year Ended December 31, 2012		
	Amount	Total Number of Shares Repurchased	Weighted Average Price Paid per Share	Amount	Total Number of Shares Repurchased	Weighted Average Price Paid per Share	Amount	Total Number of Shares Repurchased	Weighted Average Price Paid per Share
2011 repurchase plan	$164.7	3.1	$ 54.33	$ 30.7	0.7	$ 45.75	$ 89.5	2.5	$ 36.28
2014 repurchase plan	50.0	0.7	$ 68.03	—	—	N/A	—	—	N/A
Total	$214.7	3.8		$ 30.7	0.7		$ 89.5	2.5	

Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's various stockholder approved stock-based compensation plans. The Company redeemed approximately 0.1 million, 0.2 million and 0.1 million shares vested under these plans during the years ended December 31, 2014, 2013 and 2012 for an aggregate price of approximately $7.6 million, $8.4 million and $6.0 million, respectively. The Company has designated these shares as treasury stock.

Common Stock Warrant

Effective September 1, 2014, as partial consideration in connection with the Company's acquisition of Conemaugh, the Company issued a warrant to Conemaugh Health System Inc. with rights to purchase 290,514 shares of the Company's common stock at an exercise price of $74.15 per share. The warrant is exercisable ratably beginning one year from the date of issuance to three years after the date of issuance and expires ten years from the date of issuance. The warrant, classified as a liability and included under the caption "Other long-term liabilities" in the Company's accompanying consolidated balance sheets, was valued using an option pricing model and will be marked-to-market until settlement.

Comprehensive Income

Comprehensive income consists of two components: net income and other comprehensive income (loss). Other comprehensive income (loss) refers to revenues, expenses, gains and losses that in accordance with ASC 220-10 "Comprehensive Income," are recorded as an element of stockholders' equity but are excluded from net income.

Changes in the funded status of the Company's pension benefit obligations resulted in a pretax comprehensive loss of $12.0 million, or $7.8 million net of taxes, for the year ended December 31, 2014 and pretax comprehensive gains of $5.1 million and $0.2 million, or $3.2 million and $0.2 million net of taxes, for the years ended December 31, 2013 and 2012, respectively. The Company's defined benefit pension plans are further discussed in Note 10.

Note 9. Stock-Based Compensation

Overview

The Company issues stock-based awards, including stock options, appreciation rights and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with the Company's various stockholder-approved stock-based compensation plans. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 and accordingly recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 9. Stock-Based Compensation – (continued)

Stockholder Approved Stock-Based Compensation Plans

Effective June 4, 2013, upon the approval of the Company's stockholders, the Company replaced the Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and Amended and Restated Outside Directors Stock and Incentive Compensation Plan (the "ODSICP") with the 2013 Long-Term Incentive Plan (the "2013 LTIP"), a combined plan covering all of the Company's employees and non-employee directors. The 2013 LTIP provides for the grant of 3.6 million shares at a rate of 1.00 share for each stock option or appreciation rights award granted and 2.09 shares for each full-value award granted. No shares remain available for grant under the 1998 LTIP or the ODSICP.

Notwithstanding the specific grant vesting requirements, award agreements under the 2013 LTIP and the 1998 LTIP may provide for accelerated vesting in certain circumstances. Generally, award agreements provide for full vesting upon the death or disability of the participant. Some award agreements also provide for partial or full vesting upon involuntary termination of employment, provided that if the award is performance-based then the accelerated vesting would occur only if the performance goals are attained.

The Company is authorized to issue to its officers and employees shares of the Company's common stock in the form of restricted stock in accordance with the Amended and Restated Management Stock Purchase Plan ("MSPP"). The MSPP provides the Company's officers and employees an opportunity to purchase shares of the Company's common stock at a 25% discount through payroll deductions over six-month intervals. During 2012, the Company's Board of Directors suspended the right to acquire shares in accordance with the MSPP after July 1, 2012, until further notice. Accordingly, there were no shares of restricted stock granted in accordance with the MSPP during the years ended December 31, 2014 and 2013. The Company granted 51,690 shares of restricted stock to certain of its officers and employees in accordance with the MSPP during the year ended December 31, 2012. The restricted stock awards granted during the year ended December 31, 2012 cliff-vest three years from the grant date.

Stock Options

The Company granted options to purchase 716,150 and 67,000 shares of the Company's common stock to certain officers and employees in accordance with the 2013 LTIP during the years ended December 31, 2014 and 2013, respectively. Additionally, the Company granted options to purchase 735,200 and 789,800 shares of the Company's common stock to certain officers and employees in accordance with the 1998 LTIP during the years ended December 31, 2013 and 2012, respectively. Options to purchase shares granted to the Company's officers and employees in accordance with the 2013 LTIP and the 1998 LTIP were granted with an exercise price equal to the fair market value of the Company's common stock on the day of grant, based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. The options granted during the years ended December 31, 2014, 2013 and 2012 become ratably exercisable beginning one year from the date of grant to three years after the date of grant and expire ten years from the date of grant.

Valuation

The Company estimated the fair value of stock options granted using the Hull-White II ("HW-II") lattice option valuation model and a single option award approach. The Company uses the HW-II because it considers characteristics of fair value option pricing, such as an option's contractual term and the probability of exercise before the end of the contractual term. In addition, the complications surrounding the expected term of an option are material, as indicated in ASC 718-10. Given the Company's relatively large pool of unexercised options, the Company believes a lattice model that specifically addresses this fact and models a full term of exercises is the most appropriate and reliable means of valuing its stock options. The Company is

LIFEPOINT HOSPITALS, INC.

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December 31, 2014

Note 9. Stock-Based Compensation – (continued)

amortizing the fair value on a straight-line basis over the requisite service period of the awards, which is the vesting period of three years. The stock options vest 33.3% on each grant anniversary date over three years of continued employment.

The following table shows the weighted average assumptions the Company used to develop the fair value estimates under its HW-II option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
Expected volatility	29.0%	30.8%	36.0%
Risk-free interest rate, minimum	0.05	0.02	0.03
Risk-free interest rate, maximum	2.71	2.90	1.97
Expected dividends	—	—	—
Average expected term (years)	5.4	5.3	5.3
Fair value per share of stock options granted	$13.95	$11.98	$ 12.18

Population Stratification

In accordance with ASC 718-10, a company should aggregate individual awards into relatively homogeneous groups with respect to exercise and post-vesting employment behaviors for the purpose of refining the expected term assumption, regardless of the valuation technique used to estimate the fair value. In addition, ASC 718-10 indicates that a company may generally make a reasonable fair value estimate with as few as one or two groupings. The Company has determined that a single employee population group is appropriate based on an analysis of the Company's historical exercise patterns.

Expected Volatility

Volatility is a measure of the tendency of investment returns to vary around a long-term average rate. Historical volatility is an appropriate starting point for setting this assumption in accordance with ASC 718-10. According to ASC 718-10, companies should also consider how future experience may differ from the past. This may require using other factors to adjust historical volatility, such as implied volatility, peer-group volatility and the range and mean-reversion of volatility estimates over various historical periods. ASC 718-10 acknowledges that there is likely to be a range of reasonable estimates for volatility. In addition, ASC 718-10 requires that if a best estimate cannot be made, management should use the mid-point in the range of reasonable estimates for volatility. The Company estimates the volatility of its common stock at the date of grant based on both historical volatility and implied volatility from traded options of its common stock, consistent with ASC 718-10.

Risk-Free Interest Rate

Lattice models require risk-free interest rates for all potential times of exercise obtained by using a grant-date yield curve. A lattice model would, therefore, require the yield curve for the entire time period during which employees might exercise their options. The Company bases the risk-free rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Dividends

The Company has never paid any cash dividends on its common stock and does not anticipate paying any cash dividends in the foreseeable future. Accordingly, the Company uses an expected dividend yield of zero.

Pre-Vesting Forfeitures

Pre-vesting forfeitures do not affect the fair value calculation, but they affect the expense calculation. ASC 718-10 requires the Company to estimate pre-vesting forfeitures at the time of grant and revise those

Note 9. Stock-Based Compensation – (continued)

estimates in subsequent periods if actual forfeitures differ from those estimates. The Company uses historical data to estimate pre-vesting forfeitures and record share-based compensation expense only for those awards that are expected to vest.

The Company applies a dynamic forfeiture rate methodology over the vesting period of the award. The dynamic forfeiture rate methodology incorporates the lapse of time into the resulting expense calculation and results in a forfeiture rate that diminishes as the granted awards approach its vest date. Accordingly, the dynamic forfeiture rate methodology results in a more consistent stock-based compensation expense calculation over the vesting period of the award.

Post-Vesting Cancellations

Post-vesting cancellations include vested options that are cancelled, exercised or expire unexercised. Lattice models treat post-vesting cancellations and voluntary early exercise behavior as two separate assumptions. The Company uses historical data to estimate post-vesting cancellations.

Expected Term

ASC 718-10 calls for an extinguishment calculation, dependent upon how long a granted option remains outstanding before it is fully extinguished. While extinguishment may result from exercise, it can also result from post-vesting cancellation or expiration at the contractual term. Expected term is an output in lattice models so the Company does not have to determine this amount.

Stock Option Activity

A summary of stock option activity during the year ended December 31, 2014 is as follows:

Stock Options	Number Shares	Weighted Average Exercise Price	Weighted Average Fair Value	Total Fair Value	Aggregate Intrinsic Value(a)	Weighted Average Remaining Contractual Term
				(In millions)	(In millions)	(In years)
Outstanding at December 31, 2013	3,099,272	$ 36.30	$ 11.40	$ 35.3	$ 51.3	6.87
Exercisable at December 31, 2013	1,713,341	$ 31.97	$ 10.92	$ 18.7	$ 35.8	5.50
Unvested at December 31, 2013	1,385,931	$ 41.66	$ 12.00	$ 16.6	$ 15.5	8.55
Granted	716,150	$ 52.87	$ 13.95	$ 10.0	N/A	N/A
Exercised	(641,653)	$ 37.04	$ 12.55	$ (8.0)	$ 14.8	N/A
Expired (post-vest cancellation)	(959)	$ 15.23	$ 5.76	$ —	N/A	N/A
Vested	697,930	$ 40.19	$ 11.96	$ 8.3	N/A	N/A
Outstanding at December 31, 2014	3,172,810	$ 39.90	$ 11.74	$ 37.3	$ 101.6	6.80
Exercisable at December 31, 2014	1,768,659	$ 33.40	$ 10.74	$ 19.0	$ 68.1	5.44
Unvested at December 31, 2014	1,404,151	$ 48.09	$ 13.01	$ 18.3	$ 33.4	8.52

(a) The aggregate intrinsic value represents the difference between the underlying stock's market price and the stock's exercise price.

The total intrinsic value of stock options exercised during the years ended December 31, 2014, 2013 and 2012 was $14.8 million, $13.6 million and $8.3 million, respectively. The Company received $23.9 million, $39.2 million and $21.8 million in cash from stock option exercises for the years ended December 31, 2014, 2013 and 2012, respectively. The actual tax benefit realized for the tax deductions from stock option exercises totaled $1.2 million, $0.1 million and $0.7 million for the years ended December 31, 2014, 2013 and 2012, respectively.

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December 31, 2014

Note 9. Stock-Based Compensation – (continued)

As of December 31, 2014, there was $10.1 million of total estimated unrecognized compensation cost related to stock option compensation arrangements. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.3 years.

Other Stock-Based Awards

The Company granted 369,871 and 56,162 shares of other stock-based awards to certain officers, employees and non-employee directors in accordance with the 2013 LTIP during the years ended December 31, 2014 and 2013, respectively. Additionally, the Company granted 410,000 and 469,321 shares of other stock-based awards to certain officers, employees and non-employee directors in accordance with the 1998 LTIP and the ODSICP during the years ended December 31, 2013 and 2012, respectively. Excluding the fair value of the performance-based awards granted during the year ended December 31, 2014, the fair value of these other stock-based awards was determined based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. The other stock-based awards granted during the years ended December 31, 2014, 2013 and 2012 have either cliff-vesting periods from the grant date of three years, cliff-vesting periods from the grant date of six months and one day or ratable vesting periods beginning one year from the date of grant to three years after the date of grant.

Of the other stock-based awards granted during the year ended December 31, 2014, 236,000 were performance-based awards. In addition to requiring continuing service of the employee, the percentage of these restricted stock units that are earned at the end of the performance period is determined based on the Company's three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. The number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved. For valuation purposes, the awards were bifurcated into their two independent sub-award components for the portion that would be settled in the Company's common stock and for the portion that would be settled in cash and their respective fair values were estimated using the Monte-Carlo simulation valuation model. The Company recognizes compensation expense for the portion of the award that would ultimately be settled in the Company's common stock for the targeted units at its Monte-Carlo simulation value if the requisite service period is rendered, even if the market condition is never satisfied. The Company classifies as a liability and recognizes compensation expense for the portion of the award that would ultimately be settled in cash for the targeted units at its Monte-Carlo simulation value that has been and will continue to be marked-to-market until settlement. The liability related to the cash-settled portion of the award was $2.4 million at December 31, 2014.

Additionally, of the other stock-based awards granted during the years ended December 31, 2013 and 2012, 322,000 and 320,000 were performance-based, respectively. In addition to requiring continuing service of an employee, the vesting of these performance-based awards is contingent upon the satisfaction of certain financial goals, specifically related to the achievement of targeted annual revenues or earnings goals within a three-year period. If these goals are achieved, the performance-based awards will cliff-vest three years after the grant date. The performance criteria for the performance-based awards granted during the year ended December 31, 2013 have not been met and are still subject to continuing service requirements and the three year cliff-vesting provisions. The performance criteria for the performance-based awards granted during the year ended December 31, 2012 have been certified as met by the Compensation Committee of the Company's Board of Directors, however, these awards are still subject to continuing service requirements and the three year cliff-vesting provisions. For purposes of estimating compensation expense for the performance-based awards granted during the year ended December 31, 2013, the Company has assumed that the performance

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 9. Stock-Based Compensation – (continued)

goals will be achieved. If the performance goals are not met, no compensation expense will be recognized, and any previously recognized compensation expense will be reversed.

A summary of other stock-based award activity during the year ended December 31, 2014 is as follows:

Other Stock-Based Awards	Number Shares	Weighted Aggregate Fair Value(a)	Total Fair Value(a)	Average Intrinsic Value
			(In millions)	(In millions)
Outstanding at December 31, 2013	1,189,764	$ 37.79	$ 45.0	$ 62.9
Granted	369,871	$ 66.91	$ 24.8	N/A
Vested	(444,023)	$ 33.44	$ (14.8)	$ 24.0
Forfeited (pre-vest cancellation)	(7,592)	$ 15.81	$ (0.1)	N/A
Outstanding at December 31, 2014	1,108,020	$ 49.55	$ 54.9	$ 79.7
Unvested at December 31, 2014	1,026,393	$ 49.68	$ 51.0	$ 73.8

(a) Excludes the impact of changes in the fair value of performance-based awards that will be settled in cash and that have been classified as a liability.

As of December 31, 2014, there was $23.2 million of total estimated unrecognized compensation cost related to other stock-based awards granted in accordance with the 2013 LTIP, the 1998 LTIP and the MSPP. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.7 years.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 9. Stock-Based Compensation – (continued)

Summary of Stock-Based Compensation

The following table summarizes the activity in accordance with all of the Company's stock-based compensation plans for the years ended December 31, 2014, 2013 and 2012:

		Stock Options Outstanding		Other Stock-Based Awards Outstanding		Deferred Stock Units Outstanding
	Shares Available For Grant	Number of Shares	Weighted Average Grant Date Price	Number of Shares	Weighted Average Grant Date Price	Number of Shares
January 1, 2012	2,836,654	3,719,265	$ 31.97	1,523,534	$ 27.46	11,079
Increase in shares available for grant	555,000	—	—	—	—	—
Stock options granted	(789,800)	789,800	39.97	—	—	—
Other stock-based awards granted	(521,011)	—	—	521,011	36.87	—
Stock options exercised	—	(745,474)	29.34	—	—	—
Other stock-based awards vested	—	—	—	(551,511)	22.36	—
Stock options cancelled	96,546	(96,546)	35.07	—	—	—
Other stock-based awards cancelled	26,873	—	—	(26,873)	27.62	—
December 31, 2012	2,204,262	3,667,045	34.12	1,466,161	32.72	11,079
Stock options granted under the 1998 LTIP	(735,200)	735,200	44.34	—	—	—
Other stock-based awards granted under the 1998 LTIP	(410,000)	—	—	410,000	44.34	—
Stock options cancelled prior to the replacement of the 1998 LTIP with the 2013 LTIP	78,370	(78,370)	38.27	—	—	—
Other stock-based awards cancelled prior to the replacement of the 1998 LTIP with the 2013 LTIP	55,685	—	—	(55,685)	38.25	—
Cancellation of shares previously available for grant under the 1998 LTIP and ODSICP	(1,188,734)	—	—	—	—	—
Shares made available for grant under the 2013 LTIP	3,600,000	—	—	—	—	—
Stock options granted under the 2013 LTIP	(67,000)	67,000	45.96	—	—	—
Other stock-based awards granted under the 2013 LTIP[(a)]	(117,379)	—	—	56,162	47.59	—
Stock options cancelled that were originally issued under the 1998 LTIP	—	(146,565)	41.50	—	—	—
Other stock-based awards cancelled that were originally issued under the 1998 LTIP	—	—	—	(66,839)	42.30	—
Other stock-based awards cancelled under the MSPP	16,186	—	—	(16,186)	10.60	—
Stock options exercised	—	(1,145,038)	34.25	—	—	—
Other stock-based awards vested	—	—	—	(603,849)	31.31	—
December 31, 2013	3,436,190	3,099,272	36.30	1,189,764	37.79	11,079
Stock options granted	(716,150)	716,150	52.87	—	—	—
Other stock-based awards granted[(a)]	(773,030)	—	—	369,871	66.91	—
Deferred stock units vested	—	—	—	—	—	(798)
Stock options cancelled that were originally issued under the 1998 LTIP	—	(959)	15.23	—	—	—
Other stock-based awards cancelled that were originally issued under the 1998 LTIP	—	—	—	(1,335)	38.95	—
Other stock-based awards cancelled under the MSPP	6,257	—	—	(6,257)	10.87	—
Stock options exercised	—	(641,653)	37.04	—	—	—
Other stock-based awards vested	—	—	—	(444,023)	33.44	—
December 31, 2014	1,953,267[(b)]	3,172,810	$ 39.90	1,108,020	$ 49.55	10,281

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 9. Stock-Based Compensation -- (continued)

(a) Full-value awards granted under the 2013 LTIP reduce shares available for grant at a rate of 2.09 shares to 1.00 share.

(b) Of the 1,953,267 shares available for grant as of December 31, 2014, 1,926,441 are available for grant in accordance with the 2013 LTIP and 26,826 are available for grant in accordance with the MSPP.

The following table summarizes the Company's total stock-based compensation expense as well as the total recognized tax benefits related thereto for the years ended December 31, 2014, 2013 and 2012 (in millions):

	2014	2013	2012
Equity awards:			
Other stock-based awards	$ 18.0	$ 16.8	$ 16.9
Stock options	9.3	8.6	10.5
	27.3	25.4	27.4
Liability awards:			
Other stock-based awards	2.4	—	—
Total stock-based compensation expense	$ 29.7	$ 25.4	$ 27.4
Tax benefit on stock-based compensation expense	$ 11.8	$ 10.1	$ 10.9

The Company did not capitalize any stock-based compensation cost during the years ended December 31, 2014, 2013 or 2012. As of December 31, 2014, there was $33.3 million of total estimated unrecognized compensation cost related to all of the Company's stock compensation arrangements. Total estimated unrecognized compensation cost may be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted-average period of 1.6 years.

Note 10. Defined Benefit and Multiemployer Pension Plans

Defined Benefit Pension Plans

The Company provides for benefits under the Pension Plans to certain employees covered by a collective bargaining agreement at one facility and to certain non-union employees at another facility. Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan stopped accruing benefits when the Bell Pension Plan was frozen by Bell, effective October 31, 2005, prior to its assumption by the Company. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 10. Defined Benefit and Multiemployer Pension Plans – (continued)

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2014 and 2013 and the unfunded liability of the Pension Plans at December 31, 2014 and 2013 (in millions):

	2014	2013
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 43.8	$ 35.3
Benefit obligation assumed in acquisition	—	11.8
Service costs	0.5	0.8
Interest costs	2.1	1.5
Participant contributions	0.4	0.6
Actuarial loss (gain)	11.8	(6.1)
Benefits paid	(0.8)	(0.1)
Benefit obligation at end of year	57.8	43.8
Change in plan assets:		
Fair value of plan assets at beginning of year	26.1	14.9
Plan assets acquired in acquisition	—	9.5
Actual return on plan assets	1.9	0.1
Employer contributions	1.4	1.1
Participant contributions	0.4	0.6
Benefits and expenses paid	(0.8)	(0.1)
Fair value of plan assets at end of year	29.0	26.1
Unfunded liability included in other long-term liabilities in the Company's accompanying consolidated balance sheet	$ 28.8	$ 17.7

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2014, the Company recognized a pretax comprehensive loss of $12.0 million, or $7.8 million net of taxes, as a decrease in stockholders' equity through accumulated other comprehensive income (loss). For the years ended December 31, 2013 and 2012, the Company recognized pretax gains of $5.1 million and $0.2 million, or $3.2 million and $0.2 million net of taxes, respectively, as an increase in stockholder's equity through accumulated other comprehensive income (loss). These adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2014 and 2013 (in millions):

	2014	2013
Projected benefit obligation	$ 57.8	$ 43.8
Accumulated benefit obligation	$ 52.1	$ 38.8
Fair value of plan assets	$ 29.0	$ 26.1

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 10. Defined Benefit and Multiemployer Pension Plans – (continued)

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2014 and 2013 (in millions):

	2014	2013
Discount rate	3.9%	4.9%
Rate of compensation increases, when applicable	3.0%	3.0%
Expected long-term return on plan assets	7.0%	7.0%

The following table summarizes the components of net periodic costs for the years ended December 31, 2014, 2013 and 2012 (in millions):

	2014	2013	2012
Service cost	$ 0.5	$ 0.8	$ 0.2
Interest cost	2.1	1.5	0.5
Expected return on plan assets	(1.9)	(1.2)	(0.4)
Amortization of net actuarial gain	(0.2)	—	—
Total net periodic benefit cost	$ 0.5	$ 1.1	$ 0.3

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs during the years ended December 31, 2014, 2013 and 2012 (in millions):

	2014	2013	2012
Discount rate	4.9%	4.0%	3.8%
Rate of compensation increases, when applicable	3.0%	3.0%	3.0%
Expected long-term return on plan assets	7.0%	7.0%	7.0%

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. Fixed income investments include corporate and U.S. government bonds and notes as well as asset and mortgage-backed securities that employ liability-directed approaches to investments to minimize changes in the funded status of the Pension Plans. Equity securities investments include mutual funds and collective funds that are balanced to achieve an overall rate of return that minimizes the need for additional employer contributions.

On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios.

The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820-10. ASC 820-10 establishes a framework for measuring fair value and establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. The tiers are as follows:

Level 1 — defined as observable inputs such as quoted prices in active markets;

Level 2 — defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and

Level 3 — defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 10. Defined Benefit and Multiemployer Pension Plans – (continued)

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Investments in corporate and U.S. government bonds and notes are generally valued at the closing price reported in the market in which the related instrument is traded. In certain limited circumstances, other corporate debt instruments are valued based on yields currently available on comparable securities of issuers with similar credit ratings. The Pension Plans' investments in collective funds are valued at the NAV using a combination of inputs, including but not limited to quoted prices in active markets, dealer quotes who are market makers in the underlying securities and other directly and indirectly observable inputs. Investments in asset and mortgage-backed securities are valued based on external prices or on the basis of their future principal and interest payments that have been discounted to prevailing interest rates for similar investments, using market spread data and other current market assumptions on prepayments and defaults.

Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. Because all of the inputs used to value corporate and U.S. government bonds and notes, collective funds as well as asset and mortgage-backed securities are either directly or indirectly observable but other than quoted prices in active markets, the Company has classified these assets as Level 2 investments. Although quoted prices are generally available for the Pension Plans' investments in corporate and U.S. government bonds and notes, in certain limited circumstances, the markets in which the securities are distributed or traded may be limited to one or only a few brokers and vendors. Additionally, in certain other circumstances information regarding the trading volume of these investments is not always available or verifiable. The Company does not consider markets in which there are a limited number of brokers or vendors to be active.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2014 and 2013, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	December 31, 2014			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 0.6	$ 0.6	$ —	$ —
Mutual funds	17.4	17.4	—	—
Corporate bonds and notes	8.8	—	8.8	—
U.S. government and municipal bonds and notes	0.9	—	0.9	—
Asset and mortgage-backed securities	1.3	—	1.3	—
Total	$ 29.0	$ 18.0	$ 11.0	$ —

	December 31, 2013			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 0.6	$ 0.6	$ —	$ —
Mutual funds	7.9	7.9	—	—
Corporate bonds and notes	8.2	—	8.2	—
Collective funds	6.6	—	6.6	—
U.S. government and municipal bonds and notes	1.5	—	1.5	—
Asset and mortgage-backed securities	1.3	—	1.3	—
Total	$ 26.1	$ 8.5	$ 17.6	$ —

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 10. Defined Benefit and Multiemployer Pension Plans – (continued)

The Company expects to contribute approximately $1.5 million to the Pension Plans during the year ended December 31, 2015. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2015	$ 1.1
2016	1.3
2017	1.6
2018	1.9
2019	2.1
Five years thereafter	13.7
	$ 21.7

Multiemployer Pension Plan

As a result of the acquisition of Bell effective December 1, 2013, the Company became obligated to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Note 11. Commitments and Contingencies

Legal Proceedings and General Liability Claims

Hospitals are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages that may not be covered by insurance.

In addition, hospitals are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against hospitals that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from fiscal intermediaries, federal and state agencies. Any proceedings against the Company may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 11. Commitments and Contingencies – (continued)

the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on the Company's financial position, results of operations and liquidity.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within 60 days of identification. Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the Stark law); and (3) self-disclosing to the CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

In connection with the Company's acquisitions of Marquette General and Conemaugh, the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, the Company has agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, the Company will likely be responsible for funding any deficit. The Company's management believes it has made reasonable estimates of its potential exposure for these two matters and at December 31, 2014 has recorded a reserve for Marquette General of $18.0 million.

On September 16, 2013, the Company and two of its hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. On September 24, 2013, the U.S. Attorney's Office in the Southern District of West Virginia served a subpoena on Raleigh General Hospital. Raleigh General produced responsive documents to the subpoena, including patient files. The government investigations are ongoing and the Company continues to cooperate with the government in addressing these matters. Following reviews by independent interventional cardiologists, the Company notified patients of these two physicians who may have received an unnecessary procedure of such fact. The Company's efforts to locate and notify a relatively small number of these patients are ongoing.

The Company and/or Vaughan Regional Medical Center and several of its subsidiaries, as well as Dr. Seydi V. Aksut and certain parties unaffiliated with the Company, are named defendants in 13 individual lawsuits filed in December 2014, and two putative class action lawsuits, all filed in the Circuit Court of Dallas County, Alabama. These lawsuits allege that patients at Vaughan Regional Medical Center received improper interventional cardiology procedures. One of the putative class action lawsuits, filed on November 21, 2014, seeks certification of a class consisting of all Alabama citizens who underwent an invasive cardiology procedure at any LifePoint owned Alabama hospital and who received notice regarding the medical necessity of that procedure. The other putative class action lawsuit, filed on February 6, 2015, seeks certification of a class of individuals that underwent an interventional cardiology procedure that was not medically necessary and performed by Dr. Aksut. This action asserts, among other claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which, if successful, would result in the awarding of treble damages for any injury resulting from the RICO violation and attorneys' fees.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 11. Commitments and Contingencies – (continued)

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom the Company did not send notice, have been threatened and may be asserted against the Company or the hospital, and claims may also be asserted by patients at Raleigh General Hospital. Any present or future claims that are ultimately successful could result in the Company and/or the hospitals being found liable and the government investigations may also result in damages, fines and penalties. Such liability, damages and penalties could be material. The Company cannot, however, reasonably estimate the potential liability, if any, in connection with any of these matters, and no liability has been recorded as of December 31, 2014.

The Company does not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against the Company. Therefore, the final amounts paid to resolve the foregoing matters could be material and could materially differ from amounts currently recorded, if any. Any such changes in the Company's estimates or any adverse judgments will impact the Company's future results of operations and cash flows.

Physician Commitments

The Company has committed to provide certain financial assistance pursuant to recruiting agreements with various physicians practicing in the communities it serves. In consideration for a physician's relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician, normally over a period of one year, to assist in establishing the physician's practice. The Company has committed to advance a maximum amount of approximately $23.0 million at December 31, 2014. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $9.3 million and often depends upon the financial results of a physician's private practice during the guarantee period. Generally, amounts advanced under the recruiting agreements may be forgiven pro rata over a period of 36 to 48 months contingent upon the physician continuing to practice in the respective community. Pursuant to the Company's standard physician recruiting agreement, any breach or non-fulfillment by a physician under the physician recruiting agreement gives the Company the right to recover any payments made to the physician under the agreement.

Capital Expenditure Commitments

The Company is reconfiguring some of its hospitals to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in its efforts to comply with the Health Information Technology for Economic and Clinical Health Act. The Company has incurred approximately $72.9 million in costs related to uncompleted projects as of December 31, 2014, which is included under the caption "Construction in progress" in the Company's accompanying consolidated balance sheet. At December 31, 2014, these uncompleted projects had an estimated cost to complete and equip of approximately $66.1 million. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities, including its recent acquisitions. At December 31, 2014, the Company estimated its total remaining capital expenditure commitments to be approximately $1,646.8 million.

Acquisitions

The Company has historically acquired businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, medical and general professional liabilities, workers compensation liabilities, previous tax liabilities and unacceptable business practices. Although the Company institutes policies designed to conform practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 11. Commitments and Contingencies – (continued)

sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Leases

Overview

The Company leases real estate properties, buildings, vehicles and equipment under cancelable and non-cancelable leases. The leases expire at various times and have various renewal options. Certain leases that meet the lease capitalization criteria in accordance with ASC 840-10, "Leases", have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments at the inception of the lease or the fair value of the asset at the inception date. Interest rates used in computing the net present value of the lease payments are based on the Company's incremental borrowing rate at the inception of the lease. Rental expense of operating leases for the years ended December 31, 2014, 2013 and 2012 was $45.4 million, $36.5 million and $34.3 million, respectively.

Hospital Support Center Financing Lease

Under a financing lease arrangement which commenced on December 1, 2013, the Company is leasing from an unrelated third party a hospital support center for a period of just over 15 years (the "HSC Lease"). In accordance with ASC 840-40, "Leases — Sale-Leaseback Transactions", upon commencement of the HSC Lease, the Company recorded an asset under the caption "Buildings and improvements" and a related financing obligation under the caption "Long-term debt" representing the cumulative costs incurred and funded by the unrelated third party to construct the new hospital support center. The Company is depreciating the associated asset and amortizing the related financing obligation over the expected lease agreement term of just over 15 years. At the end of the lease term, the Company expects there to be a residual net book value of the building which will equal the remaining unamortized obligation under the HSC Lease. The remaining unamortized obligation under the HSC Lease will not require the eventual settlement in cash but will rather be offset by the residual net book value of the building at the expiration of the original lease term.

Future minimum lease payments at December 31, 2014, for those leases having an initial or remaining non-cancelable lease term in excess of one year are as follows for the years indicated (in millions):

	Operating Leases	Capital and Financing Lease Obligations	Total
2015	$ 26.4	$ 8.3	$ 34.7
2016	19.5	8.2	27.7
2017	16.3	7.3	23.6
2018	10.5	7.4	17.9
2019	22.3	7.4	29.7
Thereafter	30.7	62.9	93.6
	$ 125.7	$ 101.5	$ 227.2
Less: interest portion		(64.3)	
		$ 37.2	

Tax Matters

See Note 6 for a discussion of the Company's contingent tax matters.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 12. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the years ended December 31, 2014, 2013 and 2012 (dollars and shares in millions, except per share amounts):

	2014	2013	2012
Numerator for basic and diluted earnings per share attributable to LifePoint Hospitals, Inc.:			
Income from continuing operations	$ 134.9	$ 132.2	$ 155.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(8.8)	(4.4)	(3.7)
Income from continuing operations attributable to LifePoint Hospitals, Inc. stockholders	126.1	127.8	151.9
Income from discontinued operations, net of income taxes	—	0.4	—
Net income attributable to LifePoint Hospitals, Inc.	$ 126.1	$ 128.2	$ 151.9
Denominator:			
Weighted average shares outstanding – basic	44.9	46.3	47.2
Effect of dilutive securities:			
Stock options and other stock-based awards	1.8	1.3	1.2
Convertible debt instruments	0.2	—	—
Weighted average shares outstanding – diluted	46.9	47.6	48.4
Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:			
Continuing operations	$ 2.81	$ 2.76	$ 3.22
Discontinued operations	—	0.01	—
Net income	$ 2.81	$ 2.77	$ 3.22
Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:			
Continuing operations	$ 2.69	$ 2.68	$ 3.14
Discontinued operations	—	0.01	—
Net income	$ 2.69	$ 2.69	$ 3.14

The Company's convertible debt instruments have been included in the calculation of diluted earnings per share whether or not the contingent requirements were met for conversion when their conversion price was less than the average market price of the Company's common stock for the period the convertible debt instruments were outstanding. Additionally, certain outstanding stock-based awards have been included in the calculation of diluted earnings per share to the extent they were dilutive for the years ended December 31, 2014, 2013 and 2012.

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 13. Unaudited Quarterly Financial Information

The quarterly interim financial information shown below has been prepared by the Company's management and is unaudited. It should be read in conjunction with the audited consolidated financial statements appearing herein (in millions, except per share amounts):

	2014			
	First	Second	Third	Fourth
Revenues	$1,007.2	$1,047.0	$1,166.0	$ 1,262.9
Net income	37.7	41.8	28.7	26.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(0.6)	(2.7)	(1.2)	(4.3)
Net income attributable to LifePoint Hospitals, Inc.	$ 37.1	$ 39.1	$ 27.5	$ 22.4
Earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Basic	$ 0.81	$ 0.88	$ 0.61	$ 0.50
Diluted	$ 0.78	$ 0.84	$ 0.59	$ 0.48

	2013			
	First	Second	Third	Fourth
Revenues	$ 931.1	$ 894.9	$ 899.7	$ 952.6
Income from continuing operations	$ 33.0	$ 27.2	$ 34.1	$ 37.9
Income (loss) from discontinued operations, net of income taxes	0.1	0.3	0.3	(0.3)
Net income	33.1	27.5	34.4	37.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(0.7)	(0.1)	(1.6)	(2.0)
Net income attributable to LifePoint Hospitals, Inc.	$ 32.4	$ 27.4	$ 32.8	$ 35.6
Basic earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.71	$ 0.58	$ 0.70	$ 0.77
Discontinued operations	—	0.01	—	—
Net income	$ 0.71	$ 0.59	$ 0.70	$ 0.77
Diluted earnings per share attributable to LifePoint Hospitals, Inc. stockholders:				
Continuing operations	$ 0.69	$ 0.57	$ 0.68	$ 0.75
Discontinued operations	—	—	—	—
Net income	$ 0.69	$ 0.57	$ 0.68	$ 0.75

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
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Note 14. Guarantor and Non-Guarantor Supplementary Information

The 6.625% Senior Notes and the 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company's existing subsidiaries that guarantee the Senior Credit Agreement. The guarantors are 100% owned by the Company. Additionally, the guarantees are full and unconditional and are subject to customary release provisions as set forth in the agreements for the 6.625% Senior Notes and the 5.5% Senior Notes.

The condensed consolidating financial information for the parent issuer, 100% owned guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company is presented below for the years ended December 31, 2014, 2013 and 2012 and as of December 31, 2014 and 2013.

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ —	$ 3,482.6	$ 1,818.3	$ —	$ 5,300.9
Provision for doubtful accounts	—	576.5	241.3	—	817.8
Revenues	—	2,906.1	1,577.0	—	4,483.1
Salaries and benefits	29.7	1,331.5	773.3	—	2,134.5
Supplies	—	419.4	279.6	—	699.0
Other operating expenses	(0.6)	750.4	337.5	—	1,087.3
Other income	—	(56.8)	(15.1)	—	(71.9)
Equity in earnings of affiliates	(196.9)	—	—	196.9	—
Depreciation and amortization	—	180.0	70.5	—	250.5
Interest expense, net	43.4	68.9	10.7	—	123.0
Impairment charges	—	57.7	—	—	57.7
Management (income) fees	—	(45.1)	45.1	—	—
	(124.4)	2,706.0	1,501.6	196.9	4,280.1
Income from continuing operations before taxes	124.4	200.1	75.4	(196.9)	203.0
(Benefit) provision for income taxes	(1.7)	69.8	—	—	68.1
Net income	126.1	130.3	75.4	(196.9)	134.9
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	—	(1.0)	(7.8)	—	(8.8)
Net income attributable to LifePoint Hospitals, Inc.	$ 126.1	$ 129.3	$ 67.6	$ (196.9)	$ 126.1

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ —	$ 3,333.8	$ 1,094.9	$ —	$ 4,428.7
Provision for doubtful accounts	—	593.4	157.0	—	750.4
Revenues	—	2,740.4	937.9	—	3,678.3
Salaries and benefits	25.4	1,265.2	436.8	—	1,727.4
Supplies	—	398.9	178.2	—	577.1
Other operating expenses	0.8	697.2	202.9	—	900.9
Other income	—	(55.4)	(8.7)	—	(64.1)
Equity in earnings of affiliates	(182.2)	—	—	182.2	—
Depreciation and amortization	—	175.3	52.9	—	228.2
Interest expense, net	21.5	66.7	8.8	—	97.0
Debt transaction costs	5.9	—	—	—	5.9
Gain on settlement of pre-acquisition contingent obligation	—	—	(5.6)	—	(5.6)
Management (income) fees	—	(14.1)	14.1	—	—
	(128.6)	2,533.8	879.4	182.2	3,466.8
Income from continuing operations before taxes	128.6	206.6	58.5	(182.2)	211.5
Provision for income taxes	0.4	78.9	—	—	79.3
Income from continuing operations	128.2	127.7	58.5	(182.2)	132.2
Income from discontinued operations, net of taxes	—	0.4	—	—	0.4
Net income	128.2	128.1	58.5	(182.2)	132.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	—	(0.8)	(3.6)	—	(4.4)
Net income attributable to LifePoint Hospitals, Inc.	$ 128.2	$ 127.3	$ 54.9	$ (182.2)	$ 128.2

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2012
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ —	$ 3,284.2	$ 732.0	$ —	$ 4,016.2
Provision for doubtful accounts	—	514.2	110.2	—	624.4
Revenues	—	2,770.0	621.8	—	3,391.8
Salaries and benefits	27.4	1,244.6	282.5	—	1,554.5
Supplies	—	406.8	117.8	—	524.6
Other operating expenses	0.2	672.7	126.2	—	799.1
Other income	—	(27.7)	(4.3)	—	(32.0)
Equity in earnings of affiliates	(200.6)	—	—	200.6	—
Depreciation and amortization	—	155.3	37.8	—	193.1
Interest expense, net	22.4	70.7	6.9	—	100.0
Impairment charge	—	4.0	—	—	4.0
Debt transaction costs	4.4	—	—	—	4.4
Management (income) fees	—	(13.0)	13.0	—	—
	(146.2)	2,513.4	579.9	200.6	3,147.7
Income from continuing operations before taxes	146.2	256.6	41.9	(200.6)	244.1
(Benefit) provision for income taxes	(5.7)	94.2	—	—	88.5
Net income	151.9	162.4	41.9	(200.6)	155.6
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	—	(0.7)	(3.0)	—	(3.7)
Net income attributable to LifePoint Hospitals, Inc.	$ 151.9	$ 161.7	$ 38.9	$ (200.6)	$ 151.9

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 126.1	$ 130.3	$ 75.4	$ (196.9)	$ 134.9
Other comprehensive income, net of income taxes:					
Unrealized gains on changes in funded status of pension benefit obligation	(7.8)	(2.6)	(9.4)	12.0	(7.8)
Other comprehensive income	(7.8)	(2.6)	(9.4)	12.0	(7.8)
Comprehensive income	118.3	127.7	66.0	(184.9)	127.1
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	—	(1.0)	(7.8)	—	(8.8)
Comprehensive income attributable to LifePoint Hospitals, Inc.	$ 118.3	$ 126.7	$ 58.2	$ (184.9)	$ 118.3

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 128.2	$ 128.1	$ 58.5	$ (182.2)	$ 132.6
Other comprehensive income, net of income taxes:					
Unrealized gains on changes in funded status of pension benefit obligation	3.2	0.2	4.9	(5.1)	3.2
Other comprehensive income	3.2	0.2	4.9	(5.1)	3.2
Comprehensive income	131.4	128.3	63.4	(187.3)	135.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	—	(0.8)	(3.6)	—	(4.4)
Comprehensive income attributable to LifePoint Hospitals, Inc.	$ 131.4	$ 127.5	$ 59.8	$ (187.3)	$ 131.4

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2012
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 151.9	$ 162.4	$ 41.9	$ (200.6)	$ 155.6
Other comprehensive income, net of income taxes:					
Unrealized gains on changes in funded status of pension benefit obligation	0.2	—	0.2	(0.2)	0.2
Other comprehensive income	0.2	—	0.2	(0.2)	0.2
Comprehensive income	152.1	162.4	42.1	(200.8)	155.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	—	(0.7)	(3.0)	—	(3.7)
Comprehensive income attributable to LifePoint Hospitals, Inc.	$ 152.1	$ 161.7	$ 39.1	$ (200.8)	$ 152.1

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Balance Sheets
December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ —	$ 62.0	$ 129.5	$ —	$ 191.5
Accounts receivable, net	—	451.4	301.2	—	752.6
Inventories	—	71.3	43.9	—	115.2
Prepaid expenses	0.1	29.1	16.2	—	45.4
Income taxes receivable	33.0	—	—		33.0
Deferred tax assets	72.8	—	—	—	72.8
Other current assets	—	53.5	32.2	—	85.7
	105.9	667.3	523.0	—	1,296.2
Property and equipment:					
Land	—	70.0	64.8	—	134.8
Buildings and improvements	—	1,542.2	613.7	—	2,155.9
Equipment	—	1,289.9	343.9	—	1,633.8
Construction in progress	—	49.6	23.3	—	72.9
	—	2,951.7	1,045.7	—	3,997.4
Accumulated depreciation	—	(1,398.3)	(221.6)	—	(1,619.9)
	—	1,553.4	824.1	—	2,377.5
Deferred loan costs, net	31.7	—	—	—	31.7
Intangible assets, net	—	34.6	34.5	—	69.1
Investments in subsidiaries	2,025.6	—	—	(2,025.6)	—
Due from subsidiaries	2,352.1	—	—	(2,352.1)	—
Other assets	6.6	19.4	20.4	—	46.4
Goodwill	—	1,440.5	195.6	—	1,636.1
Total assets	$ 4,521.9	$ 3,715.2	$ 1,597.6	$(4,377.7)	$ 5,457.0
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ —	$ 90.4	$ 68.1	$ —	$ 158.5
Accrued salaries	—	130.9	71.5	—	202.4
Other current liabilities	14.5	112.7	76.0	—	203.2
Current maturities of long-term debt	16.9	0.9	1.4	—	19.2
	31.4	334.9	217.0	—	583.3
Long-term debt	2,137.5	49.1	12.7	—	2,199.3
Due to Parent	—	1,634.6	717.5	(2,352.1)	—
Deferred income tax liabilities	187.5	—	—	—	187.5
Long-term portion of reserves for self-insurance claims	—	103.1	30.1	—	133.2
Other long-term liabilities	10.9	24.7	49.1	—	84.7
Total liabilities	2,367.3	2,146.4	1,026.4	(2,352.1)	3,188.0
Redeemable noncontrolling interests	—	—	87.1	—	87.1
Total LifePoint Hospitals, Inc. stockholders' equity	2,154.6	1,567.0	458.6	(2,025.6)	2,154.6
Noncontrolling interests	—	1.8	25.5	—	27.3
Total equity	2,154.6	1,568.8	484.1	(2,025.6)	2,181.9
Total liabilities and equity	$ 4,521.9	$ 3,715.2	$ 1,597.6	$(4,377.7)	$ 5,457.0

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Balance Sheets
December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ —	$ 558.3	$ 79.6	$ —	$ 637.9
Accounts receivable, net	—	444.3	151.4	—	595.7
Inventories	—	73.4	28.6	—	102.0
Prepaid expenses	0.1	30.6	7.3	—	38.0
Deferred tax assets	147.7	—	—	—	147.7
Other current assets	—	53.0	19.9	—	72.9
	147.8	1,159.6	286.8	—	1,594.2
Property and equipment:					
Land	—	76.0	36.3	—	112.3
Buildings and improvements	—	1,570.1	449.5	—	2,019.6
Equipment	—	1,256.4	213.5	—	1,469.9
Construction in progress	—	45.6	13.1	—	58.7
	—	2,948.1	712.4	—	3,660.5
Accumulated depreciation	—	(1,309.0)	(154.3)	—	(1,463.3)
	—	1,639.1	558.1	—	2,197.2
Deferred loan costs, net	31.1	—	—	—	31.1
Intangible assets, net	—	40.3	32.3	—	72.6
Investments in subsidiaries	1,853.1	—	—	(1,853.1)	—
Due from subsidiaries	2,760.4	—	—	(2,760.4)	—
Other assets	3.4	22.4	14.9	—	40.7
Goodwill	—	1,435.1	215.9	—	1,651.0
Total assets	$ 4,795.8	$ 4,296.5	$ 1,108.0	$(4,613.5)	$ 5,586.8
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ —	$ 99.1	$ 36.8	$ —	$ 135.9
Accrued salaries	—	102.1	37.5	—	139.6
Other current liabilities	14.8	146.4	36.0	—	197.2
Current maturities of long-term debt	581.4	0.7	0.9	—	583.0
	596.2	348.3	111.2	—	1,055.7
Long-term debt	1,739.8	50.0	4.0	—	1,793.8
Due to Parent	—	2,324.8	435.6	(2,760.4)	—
Deferred income tax liabilities	233.1	—	—	—	233.1
Long-term portion of reserves for self-insurance claims	—	113.5	26.3	—	139.8
Other long-term liabilities	16.6	20.2	35.2	—	72.0
Total liabilities	2,585.7	2,856.8	612.3	(2,760.4)	3,294.4
Redeemable noncontrolling interests	—	—	59.8	—	59.8
Total LifePoint Hospitals, Inc. stockholders' equity	2,210.1	1,438.2	414.9	(1,853.1)	2,210.1
Noncontrolling interests	—	1.5	21.0		22.5
Total equity	2,210.1	1,439.7	435.9	(1,853.1)	2,232.6
Total liabilities and equity	$ 4,795.8	$ 4,296.5	$ 1,108.0	$(4,613.5)	$ 5,586.8

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2014
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 126.1	$ 130.3	$ 75.4	$ (196.9)	$ 134.9
Adjustments to reconcile net income to net cash provided by operating activities:	—	—	—	—	—
Equity in earnings of affiliates	(196.9)	—	—	196.9	—
Stock-based compensation	27.3	—	—	—	27.3
Depreciation and amortization	—	180.0	70.5	—	250.5
Amortization of physician minimum revenue guarantees	—	13.1	1.6	—	14.7
Amortization of debt discounts, premium and deferred loan costs	14.0	—	—	—	14.0
Impairment charges	—	57.7	—	—	57.7
Deferred income taxes	22.8	—	—	—	22.8
Reserve for self-insurance claims, net of payments	—	7.9	3.8	—	11.7
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	—	(5.9)	(48.4)	—	(54.3)
Inventories, prepaid expenses and other current assets	—	(6.1)	(12.5)	—	(18.6)
Accounts payable, accrued salaries and other current liabilities	2.4	(38.6)	21.8	—	(14.4)
Income taxes payable/receivable	(35.5)	—	—	—	(35.5)
Other	(0.8)	1.8	0.5	—	1.5
Net cash (used in) provided by operating activities	(40.6)	340.2	112.7	—	412.3
Cash flows from investing activities:					
Purchases of property and equipment	—	(139.0)	(68.1)	—	(207.1)
Acquisitions, net of cash acquired	—	(11.4)	(254.2)	—	(265.6)
Other	(3.2)	3.3	(0.6)	—	(0.5)
Net cash used in investing activities	(3.2)	(147.1)	(322.9)	—	(473.2)
Cash flows from financing activities:					
Proceeds from borrowings	412.0	—	—	—	412.0
Payments of borrowings	(585.4)	—	—	—	(585.4)
Repurchases of common stock	(222.3)	—	—	—	(222.3)
Payments of debt financing costs	(7.2)	—	—	—	(7.2)
Proceeds from exercise of stock options	23.9	—	—	—	23.9
Change in intercompany balances with affiliates, net	423.0	(689.9)	266.9	—	—
Other	(0.2)	0.5	(6.8)	—	(6.5)
Net cash provided by (used in) financing activities	43.8	(689.4)	260.1	—	(385.5)
Change in cash and cash equivalents	—	(496.3)	49.9	—	(446.4)
Cash and cash equivalents at beginning of period	—	558.3	79.6	—	637.9
Cash and cash equivalents at end of period	$ —	$ 62.0	$ 129.5	$ —	$ 191.5

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2013
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 128.2	$ 128.1	$ 58.5	$ (182.2)	$ 132.6
Adjustments to reconcile net income to net cash provided by operating activities:					
Income from discontinued operations	—	(0.4)	—	—	(0.4)
Equity in earnings of affiliates	(182.2)	—	—	182.2	—
Stock-based compensation	25.4	—	—	—	25.4
Depreciation and amortization	—	175.3	52.9	—	228.2
Amortization of physician minimum revenue guarantees	—	15.5	1.7	—	17.2
Amortization of debt discounts and deferred loan costs	26.9	—	—	—	26.9
Debt transaction costs	5.9	—	—	—	5.9
Gain on settlement of pre-acquisition contingent obligation	—	—	(5.6)	—	(5.6)
Deferred income tax benefit	(20.4)	—	—	—	(20.4)
Reserve for self-insurance claims, net of payments	—	(0.7)	4.0	—	3.3
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	—	(22.9)	(4.1)	—	(27.0)
Inventories, prepaid expenses and other current assets	—	(15.0)	(2.1)	—	(17.1)
Accounts payable, accrued salaries and other current liabilities	(0.1)	(10.9)	(5.3)	—	(16.3)
Income taxes payable/receivable	1.8	—	—	—	1.8
Other	—	(0.7)	0.3	—	(0.4)
Net cash (used in) provided by operating activities – continuing operations	(14.5)	268.3	100.3	—	354.1
Net cash used in operating activities – discontinued operations	—	(0.1)	—	—	(0.1)
Net cash (used in) provided by operating activities	(14.5)	268.2	100.3	—	354.0
Cash flows from investing activities:					
Purchases of property and equipment	—	(149.4)	(35.8)	—	(185.2)
Acquisitions, net of cash acquired	—	(46.4)	(141.7)	—	(188.1)
Other	(1.9)	1.3	1.6	—	1.0
Net cash used in investing activities	(1.9)	(194.5)	(175.9)	—	(372.3)
Cash flows from financing activities:					
Proceeds from borrowings	1,053.0	—	—	—	1,053.0
Payments of borrowings	(453.7)	—	—	—	(453.7)
Repurchases of common stock	(39.1)	—	—	—	(39.1)
Payments of debt financing costs	(20.0)	—	—	—	(20.0)
Proceeds from exercise of stock options	39.2	—	—	—	39.2
Change in intercompany balances with affiliates, net	(562.6)	459.7	102.9	—	—
Other	(0.4)	(0.1)	(7.7)	—	(8.2)
Net cash provided by financing activities	16.4	459.6	95.2	—	571.2
Change in cash and cash equivalents	—	533.3	19.6	—	552.9
Cash and cash equivalents at beginning of period	—	25.0	60.0	—	85.0
Cash and cash equivalents at end of period	$ —	$ 558.3	$ 79.6	$ —	$ 637.9

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 14. Guarantor and Non-Guarantor Supplementary Information – (continued)

LIFEPOINT HOSPITALS, INC.

Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2012
(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 151.9	$ 162.4	$ 41.9	$ (200.6)	$ 155.6
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(200.6)	—	—	200.6	—
Stock-based compensation	27.4	—	—	—	27.4
Depreciation and amortization	—	155.3	37.8	—	193.1
Amortization of physician minimum revenue guarantees	—	17.7	1.9	—	19.6
Amortization of debt discounts and deferred loan costs	31.4	—	—	—	31.4
Impairment charge	—	4.0	—	—	4.0
Debt transaction costs	4.4	—	—	—	4.4
Deferred income tax benefit	(24.2)	—	—	—	(24.2)
Reserve for self-insurance claims, net of payments	—	0.3	1.3	—	1.6
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	—	(26.1)	(17.2)	—	(43.3)
Inventories, prepaid expenses and other current assets	—	(4.4)	(5.3)	—	(9.7)
Accounts payable, accrued salaries and other current liabilities	(1.6)	11.1	10.0	—	19.5
Income taxes payable/receivable	2.3	—	—	—	2.3
Other	—	2.1	(0.9)	—	1.2
Net cash (used in) provided by operating activities – continuing operations	(9.0)	322.4	69.5	—	382.9
Net cash used in operating activities – discontinued operations	—	(0.7)	—	—	(0.7)
Net cash (used in) provided by operating activities	(9.0)	321.7	69.5	—	382.2
Cash flows from investing activities:					
Purchases of property and equipment	—	(196.0)	(25.4)	—	(221.4)
Acquisitions, net of cash acquired	—	(40.3)	(159.4)	—	(199.7)
Other	(0.5)	(0.5)	—	—	(1.0)
Net cash used in investing activities	(0.5)	(236.8)	(184.8)	—	(422.1)
Cash flows from financing activities:					
Proceeds from borrowings	555.0	—	—	—	555.0
Payments of borrowings	(469.3)	—	—	—	(469.3)
Repurchases of common stock	(95.5)	—	—	—	(95.5)
Payments of debt financing costs	(10.0)	—	—	—	(10.0)
Proceeds from exercise of stock options	21.8	—	—	—	21.8
Change in intercompany balances with affiliates, net	6.3	(166.0)	159.7	—	—
Other	1.2	(0.2)	(4.3)	—	(3.3)
Net cash provided by (used in) financing activities	9.5	(166.2)	155.4	—	(1.3)
Change in cash and cash equivalents	—	(81.3)	40.1	—	(41.2)
Cash and cash equivalents at beginning of period	—	106.3	19.9	—	126.2
Cash and cash equivalents at end of period	$ —	$ 25.0	$ 60.0	$ —	$ 85.0

LIFEPOINT HOSPITALS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2014

Note 15. Subsequent Event

Effective February 1, 2015, through Duke LifePoint Healthcare, the Company acquired Nason Hospital ("Nason"), a 45 bed acute care hospital located in Roaring Spring, Pennsylvania for approximately $3.5 million, including net working capital. The Company has committed to invest in Nason an additional $8.5 million in capital expenditures and improvements over the next ten years. Nason will operate as part of Conemaugh Health System.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Brentwood, State of Tennessee, on February 12, 2015.

LIFEPOINT HOSPITALS, INC.

By:/s/ WILLIAM F. CARPENTER III

William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the date indicated.

Name	Title	Date
/s/ WILLIAM F. CARPENTER III William F. Carpenter III	Chief Executive Officer and Chairman of the Board of Directors (Principal Executive Officer)	February 12, 2015
/s/ LEIF M. MURPHY Leif M. Murphy	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 12, 2015
/s/ MICHAEL S. COGGIN Michael S. Coggin	Chief Accounting Officer (Principal Accounting Officer)	February 12, 2015
/s/ GREGORY T. BIER Gregory T. Bier	Director	February 12, 2015
/s/ RICHARD H. EVANS Richard H. Evans	Director	February 12, 2015
/s/ DEWITT EZELL, JR. DeWitt Ezell, Jr.	Director	February 12, 2015
/s/ MICHAEL P. HALEY Michael P. Haley	Director	February 12, 2015
/s/ MARGUERITE W. KONDRACKE Marguerite W. Kondracke	Director	February 12, 2015
/s/ JOHN E. MAUPIN, JR. John E. Maupin, Jr.	Director	February 12, 2015
/s/ OWEN G. SHELL, JR. Owen G. Shell, Jr.	Lead Director	February 12, 2015
/s/ REED V. TUCKSON Reed V. Tuckson	Director	February 12, 2015

Exhibit Number		Description of Exhibits
3.1	—	Amended and Restated Certificate of Incorporation (incorporated by reference from exhibits to the Registration Statement on Form S-8 filed by LifePoint Hospitals, Inc. on April 19, 2005, File No. 333-124151).
3.2	—	Fifth Amended and Restated By-Laws of LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed September 17, 2014, File No. 000-51251).
4.1	—	Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929).
4.2	—	Amended and Restated Rights Agreement, dated February 25, 2009, by and between LifePoint Hospitals, Inc. and American Stock Transfer & Trust Company, LLC (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated February 25, 2009, File No. 000-51251).
4.3	—	Indenture, dated May 29, 2007, by and between LifePoint Hospitals, Inc. as Issuer and The Bank of New York Trust Company, N.A., as Trustee (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 31, 2007, File No. 000-51251).
4.4	—	Indenture, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 6.625% Senior Notes due 2020) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 27, 2010, File No. 000-51251).
4.5	—	Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 5.5% Senior Note due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 9, 2013, File No. 000-51251).
4.6	—	Registration Rights Agreement, dated September 23, 2010, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 27, 2010, File No. 000-51251).
4.7	—	Registration Rights Agreement, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 9, 2013, File No. 000-51251).
4.8	—	Registration Rights Agreement, dated as of May 12, 2014, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Barclays Capital Inc. as representative of the several initial purchasers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 13, 2014, File No. 000-51251).
10.1	—	Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 21, 2008, File No. 000-51251).

Exhibit Number		Description of Exhibits
10.2	—	Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA — Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).
10.3	—	LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*
10.4	—	Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.5	—	LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).*
10.6	—	First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*
10.7	—	Amendment No. 2 to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed June 6, 2014, File No. 000-51251).*
10.8	—	Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.9	—	LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 16, 2008, File No. 000-51251).*
10.10	—	LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).*
10.11	—	Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).*
10.12	—	Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).*
10.13	—	LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*

Exhibit Number		Description of Exhibits
10.14	—	Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*
10.15	—	LifePoint Hospitals Deferred Compensation Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 15, 2009, File No. 000-51251).*
10.16	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated December 22, 2010 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*
10.17	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated March 14, 2011 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, File No. 000-51251).*
10.18	—	Amendment to the LifePoint Hospitals Deferred Compensation Plan, dated November 24, 2014 (filed herewith).*
10.19	—	Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents, and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Barclays Bank PLC, as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).
10.20	—	Incremental Facility Amendment No. 1, dated as of February 6, 2013, by and among LifePoint Hospitals, Inc., as borrower, the lenders referred to therein, Citibank, N.A., as administrative agent, and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as leads arrangers, to the Credit Agreement, dated as of July 24, 2012, among Borrower, the lenders referred to therein, Citibank, N.A. as administrative agent, Bank of America, N.A. and Barclays Bank PLC as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated February 7, 2013, File No. 000-51251).
10.21	—	Credit Agreement Amendment No. 2, dated as of August 23, 2013, by and among LifePoint Hospitals, Inc., the lenders party thereto, Citibank, N.A., as administrative agent and consented to by Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC, as lead arrangers, to that certain Credit Agreement, dated as of July 24, 2012, among LifePoint Hospitals, Inc., the lenders party thereto, the Administrative Agent, Bank of America, N.A. and Barclays Bank PLC, as co-syndication agents and Citigroup Global Markets Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Bank PLC as joint lead arrangers and joint bookrunners, as amended by Incremental Facility Amendment No. 1 dated as of February 6, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated August 26, 2013, File No. 000-51251).
10.22	—	Executive Severance and Restrictive Covenant Agreement, dated December 11, 2008, by and between LifePoint CSGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*

Exhibit Number		Description of Exhibits
10.23	—	First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated December 17, 2012, File No. 000-51251).*
10.24	—	Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated May 20, 2008, File No. 000-51251).*
10.25	—	LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from Appendix A to the LifePoint Hospitals, Inc. Proxy Statement filed April 24, 2013, File No. 000-51251).*
10.26	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (Performance-Based Vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.27	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.28	—	Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement for the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.29	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement for non-employee directors (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, File No. 000-51251).*
10.30	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.31	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.32	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.33	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.34	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (filed herewith).*
10.35	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Non-Qualified Stock Option Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.36	—	Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).*

Exhibit Number		Description of Exhibits
10.37	—	Voluntary Resignation Agreement and General Release by and between Jeffrey S. Sherman and HSGCP, LLC, dated September 4, 2013 (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K dated September 6, 2013, File No. 000-51251).*
12.1	—	Ratio of Earnings to Fixed Charges
21.1	—	List of Subsidiaries
23.1	—	Consent of Independent Registered Public Accounting Firm
31.1	—	Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	—	Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002
32.1	—	Certification of the Chief Executive Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	—	Certification of the Chief Financial Officer of LifePoint Hospitals, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002
101.INS	—	XBRL Instance Document**
101.SCH	—	XBRL Taxonomy Extension Schema Document**
101.CAL	—	XBRL Taxonomy Calculation Linkbase Document**
101.DEF	—	XBRL Taxonomy Definition Linkbase Document**
101.LAB	—	XBRL Taxonomy Label Linkbase Document**
101.PRE	—	XBRL Taxonomy Presentation Linkbase Document**

* — Management Compensation Plan or Arrangement

** — Furnished electronically herewith

Exhibit 10.18

AMENDMENT TO THE LIFEPOINT HOSPITALS DEFERRED COMPENSATION PLAN

THIS AMENDMENT to the LifePoint Hospitals Deferred Compensation Plan (the "Plan") is made on this 24th day of November, 2014, by LifePoint Hospitals, Inc. (the "Company").

WHEREAS, the Company heretofore adopted the Plan for the benefit of its eligible employees;

WHEREAS, the Company has reserved the right to amend the Plan; and

WHEREAS, the Company desires to amend the Plan to allow eligible individuals to defer restricted stock units granted pursuant to the Company's long-term incentive plan and provide certain terms for special discretionary matching contributions;

NOW, THEREFORE, the Plan is hereby amended as follows, effective November 1, 2014:

I. The following new Section 2.10A is added:

2.10A "Deferred Matching Contribution" means a matching contribution made by the Company pursuant to Section 3.3(b).

II. Subsections 3.2(b) and (c) are deleted and replaced in its entirety with the following:

(b) *Special Initial Elections.* The Company may permit Eligible Individuals to make the following special initial elections in its complete and absolute discretion.

(i) Pursuant to the terms of Treas. Reg. §1.409A-2(a)(5), if an Eligible Individual is granted a right to receive compensation in a subsequent year, subject to a condition that he or she continue to provide services for the Company for at least 12 months from the date such right is granted in order to avoid forfeiture of such right, the Eligible Individual may make an election to defer such compensation at any time within 30 days of the date he or she is granted the right to such compensation, provided the election is made at least 12 months prior to the earliest date at which the forfeiture condition could lapse.

(ii) Pursuant to the terms of Treas. Reg. §1.409A-2(a)(8), if an Eligible Individual is granted performance-based compensation (as defined in Treas. Reg. §1.409A-1(e)), he or she may make an election to defer such performance-based compensation at any time on or before the date that is six months before the end of the performance period or such longer period as may be established by the Committee; provided, however, that the Eligible Individual performs services continuously from the later of (A) the beginning of the performance period or (B) the date the performance criteria are established through the date an election is made, and provided further that in no event may an election to defer performance-based compensation be made after such compensation has become readily ascertainable.

(c) *Limitations on the Amount of Elections.* An Eligible Individual may make a Deferral election described in this Section 3.2 to defer the receipt of up to 50% of his or her annual base compensation that is paid through regular periodic payroll during each Plan Year. In addition, an Eligible Individual may defer the receipt of up to 100% of any performance-based compensation (as defined in Treas. Reg. §1.409A-1(e)), restricted stock units (provided, and only to the extent that, the award agreement for such restricted stock units permits a Deferral), or year-end bonus to be paid with respect to such Plan Year. The amount of a Deferral election shall be stated either as a dollar amount or a percentage of a Participant's cash compensation, except as otherwise provided by the Committee. A Deferral election with respect to a bonus or performance-based compensation (as defined in Treas. Reg. §1.409A-1(e)) may be stated as an amount over a dollar threshold (*e.g.*, 10% over $50,000). A Deferral election with respect to any award of restricted stock units pursuant to any equity-based long-term incentive plan maintained by the Company may be stated as a dollar amount or as a number of restricted stock units.

(i) Unless otherwise specified in a Deferral election that is authorized by the Committee, the Company shall withhold the amount elected pro rata from each payroll period while the election is in effect.

(ii) Deferrals will be withheld from a Participant's compensation in accordance with the Participant's written Deferral elections. The Company will withhold from that portion of a Participant's compensation that is not deferred, in a manner determined by the Committee, applicable withholding and other taxes applicable to any Deferrals or Company Contributions.

III. Section 3.3 is deleted and replaced in its entirety with the following:

3.3 Company Contributions.

(a) The Company may in its discretion make a Contribution to be credited to the Account of any or all Participants and/or Eligible Individuals, or may make Contributions only to those Participants who made a Deferral election for such Plan Year. Unless otherwise specified by the Company and except as provided in subsection (b) below, Company Contributions shall be effective as of the last day of each Plan Year and shall be allocated to Accounts of Eligible Individuals who are employed or providing services on the last day of the Plan Year.

(b) Notwithstanding any other provision to the contrary, the Company may make a Deferred Matching Contribution to the Accounts of those Participants designated by the Committee, in an amount equal to a percentage of all or a portion of a Participant's Deferrals for such Plan Year, as determined by the Committee in its sole discretion, provided that no Deferred Matching Contributions will be made with respect to any Deferrals of base compensation and/or bonus earned, or restricted stock units granted, in any Plan Year in which the Company suspends matching contributions to the Company's qualified retirement plans. Deferred Matching Contributions made with respect to a Participant's Deferral of base compensation and/or bonus to be paid for the applicable Plan Year shall be effective as of the first day of the applicable Plan Year. Deferred Matching Contributions made with respect to a Participant's Deferral of restricted stock units granted in the applicable Plan Year shall be effective as of the date the Participant's Deferral election is effective. The Committee may impose any additional terms and conditions that are not inconsistent with the Plan on such Deferred Matching Contributions as the Committee shall determine in its sole discretion, including but not limited to additional eligibility criteria.

(c) All elections with respect to the time and form of payment made regarding Deferrals of base compensation and/or bonus (as applicable) for a Plan Year pursuant to Section 5.1 will apply to all Company Contributions applicable to the same Plan Year, which, for the avoidance of doubt, includes Deferred Matching Contributions which relate to deferred restricted stock units granted during such Plan Year regardless of when a Participant makes an election to defer such restricted stock units.

IV. Section 3.5 is deleted and replaced in its entirety with the following:

3.5 Vesting.

(a) Participant Deferrals are 100% vested and nonforfeitable at all times.

(b) Deferred Matching Contributions are fully vested and nonforfeitable when they are credited to the Participant's Account, provided, however, that (i) all Deferred Matching Contributions (adjusted for earnings and losses) that are made with respect to any Deferrals of base compensation and/or bonus earned, or restricted stock units granted, in any Plan Year in which the Company suspends matching contributions to the Company's qualified retirement plans shall be forfeited; (ii) a Participant who voluntarily terminates employment within six (6) months after the Participant's most recent deferral election will forfeit the most recent Deferred Matching Contribution, and (iii) a Participant will forfeit all Deferred Matching Contributions if (A) the Participant's employment is terminated for "cause," or (B) within one (1) year after the Participant's voluntary termination of employment, the Participant violates the nonsolicitation agreement between the Participant and the Company on the Participant's deferral election form. For purposes of this Plan, "cause" means (x) any action by the Participant constituting fraud, self-dealing, embezzlement, or dishonesty in the course of his or her employment, or (y) the conviction of the Participant of a crime involving moral turpitude or any felony.

(c) Company Contributions other than Deferred Matching Contributions shall become vested and nonforfeitable based on a Participant's Years of Service according to the following schedule:

Years of Service	Percent Vested
Less than 2	0%
2 or more	100%

Notwithstanding the foregoing, all Accounts shall be fully vested upon a Change in Control of the Company.

IN WITNESS WHEREOF, the undersigned has executed this instrument on behalf of the Company to amend the Plan on the date first written above, to be effective as provided herein.

By: /s/ John P. Bumpus

Title: Executive Vice President and Chief Administrative Officer

Exhibit 10.34

Form of Award – RSU
(Performance-based Vesting; Deferral Provision)

LIFEPOINT HOSPITALS, INC.
2013 LONG-TERM INCENTIVE PLAN
RESTRICTED STOCK UNIT AGREEMENT

FOR

____

Grant Number ____________________

1. *Award of Restricted Stock Units.* LifePoint Hospitals, Inc. (the "**Company**") grants, as of __________________ (the "**Date of Grant**"), to __________________ (the "**Recipient**"), ______________ Restricted Stock Units (the "**RSUs**"). Each RSU represents the Company's unsecured obligation to pay the Recipient, in Shares or a combination of Shares and cash, up to 200% of the Fair Market Value of a Share. The RSUs shall be subject to the terms, provisions and restrictions set forth in this Agreement and the LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (the "**Plan**"), which is incorporated herein for all purposes. The grant of this Award, the issuance of any Shares (or any other securities of the Company pursuant thereto) and, if applicable, payment of cash, is subject to all of the terms and conditions herein and in the Plan. Unless otherwise provided herein, terms used herein that are defined in the Plan and not defined herein shall have the meanings attributable thereto in the Plan.

2. *Vesting of RSUs.*

(a) *Performance Requirement.*

(i) The percentage of the Fair Market Value of a Share which is payable per RSU (the "**Percentage Payable**") shall be determined, except as otherwise provided in this Agreement, according to the table below (the "**Performance Goals**"), based on the Company's three-year annualized total shareholder return (the "**3-Year TSR**") relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-industry: Health Care Facilities with over $500.0 million in revenues or its equivalent (the "**Relative 3-Year TSR**"), during the Performance Period:

Relative 3-Year TSR Achieved	Percentage Payable
Below 25th Percentile	0%
25th Percentile	50%
37.5 Percentile	75%
50th Percentile	100%
62.5 Percentile	150%
75th Percentile or higher	200%

The Percentage Payable will be determined using straight line interpolation if the level of Relative 3-Year TSR achieved is between two of the levels specified in the chart above.

(ii) The "Performance Period" for the Award is January 1, 20__, through December 31, 20__.

(iii) The Company's 3-Year TSR shall be determined using the Company's stock price average for the last thirty (30) trading days in 20__ and the last thirty (30) trading days in 20__.

(iv) Payment of the RSUs is conditioned upon the Committee certifying in writing upon the completion of the Performance Period that the Performance Goals specified herein were achieved and, if so, the level at which the Performance Goals are achieved, except as otherwise provided in this Agreement. If the objectives are not achieved, the RSUs will be forfeited and shall not vest and no payment shall be made hereunder.

(v) Performance shall be determined in accordance with generally accepted accounting principles; provided, however, that such performance shall be determined without regard to any change in accounting standards that may be required by the Financial Accounting Standards Board during the Performance Period, and by making appropriate adjustments to account for any spin-off or sale of a subsidiary or the disposition of assets by the Company during the Performance Period. Any such adjustments shall be made in a manner that (A) does not result in a discretionary increase in the amount payable under the Award and (B) is otherwise consistent with the qualification of Awards as "performance-based compensation" under Code Section 162(m) and the regulations thereunder.

(vi) Except as otherwise provided in this Agreement, there shall be no proportionate or partial vesting of the RSUs in or during the months, days or periods prior to the Vesting Date and all vesting of the RSUs shall occur only on the Vesting Date.

(b) General Vesting Except as otherwise provided in this Agreement, the RSUs subject to this Agreement will vest on __________ (the "Vesting Date"), provided that the Continuous Service of the Recipient continues through and on the Vesting Date and the Performance Goals are met.

(c) Acceleration of Vesting Upon Death. Notwithstanding any other provision in this Agreement, in the event that the Recipient's Continuous Service terminates before the Vesting Date by reason of the Recipient's death, the RSUs subject to this Agreement shall be immediately vested as of the date of such death, and the Percentage Payable per RSU shall be one hundred percent (100%) or, if greater, the percentage determined pursuant to Section 2(a) above, except that such determination shall be based on the period beginning January 1, 20__ and ending on the date of the Recipient's death and the last thirty (30) trading days immediately prior to the Recipient's death shall be used to measure performance.

(d) *Acceleration of Vesting Upon Disability.* Notwithstanding any other provision in this Agreement, in the event that the Recipient suffers a Disability prior to the Vesting Date, the RSUs subject to this Agreement shall be immediately vested as of the date of such Disability, and the Percentage Payable per RSU shall be one hundred percent (100%) or, if greater, the percentage determined pursuant to Section 2(a) above, except that such determination shall be based on the period beginning January 1, 20__ and ending on the date of the Recipient's Disability and the last thirty (30) trading days immediately prior to the Recipient's Disability shall be used to measure performance.

(e) ***Acceleration of Vesting Upon a 409A Change in Control.*** Notwithstanding any other provision in this Agreement or the Plan, upon a 409A Change in Control during the Recipient's Continuous Service, the RSUs subject to this Agreement shall be immediately vested as of the date of such event and the Percentage Payable per RSU shall be two hundred percent (200%), unless either (i) the Company is the surviving entity in the 409A Change in Control and the RSU Award continues to be outstanding after the 409A Change in Control on substantially the same terms and conditions as were applicable immediately prior to the 409A Change in Control, or (ii) the successor company or its parent company assumes or substitutes for the RSU Award, as determined in accordance with Section 10(c)(ii) of the Plan. Notwithstanding the foregoing, in the event the Recipient's Continuous Service is terminated without Cause by the Company or any Related Entity or by such successor company or by the Recipient for Good Reason within 24 months following a 409A Change in Control and the RSUs subject to this Agreement did not vest pursuant to subsection (i) or (ii) of this Section 2(e), the RSUs subject to this Agreement shall be immediately vested as of the date of such termination of Continuous Service and the Percentage Payable per RSU shall be two hundred percent (200%).

(f) ***Acceleration of Vesting Upon Termination.*** Notwithstanding any other provision in this Agreement and except as otherwise provided in Section 2(g), in the event that the Recipient's Continuous Service is terminated prior to the Vesting Date either by the Company or any Related Entity without Cause or by the Recipient for Good Reason, a portion of the RSUs equal to (i) the number of full months of Continuous Service following the Date of Grant through the date of termination, divided by (ii) the total number of months between the Date of Grant and the Vesting Date, shall become vested as of the Vesting Date, provided that the Performance Goals described herein are attained during the Performance Period. The Percentage Payable per RSU shall be the percentage, if any, determined and certified by the Committee pursuant to Section 2(a) above.

(g) ***Acceleration of Vesting Upon Retirement.*** Notwithstanding any other provision in this Agreement, if the Recipient terminates his or her Continuous Service prior to the Vesting Date and after attaining age 62 (for reasons other than the reasons described in Sections 2(c), 2(d), 2(e) and 2(f) hereof) and completing at least five (5) years of Continuous Service (a "**Retirement Termination**"), the RSUs shall vest on the Vesting Date, provided that the Performance Goals described herein are attained during the Performance Period and provided further that, during the period (the "**Restricted Period**") beginning on the date the Recipient has a Retirement Termination (the "**Retirement Date**") and continuing until the Vesting Date, the Recipient agrees that he or she will not, in any capacity (including, but not limited to, as an owner, member, partner, shareholder, consultant, advisor, financier, agent, employee, officer, director, manager or otherwise), whether directly or indirectly, engage in a Competitive Activity (as such term is hereinafter defined). If the Recipient fails to comply with this provision, a portion of the RSUs equal to (i) the number of full months following the Date of Grant through the date the Recipient violates this provision, divided by (ii) the total number of months between the Date of Grant and the Vesting Date, shall become vested as of the Vesting Date, provided that the Performance Goals described herein are attained during the Performance Period, and the unvested portion of the RSUs shall be forfeited. The Percentage Payable per RSU under this Subsection shall be the percentage, if any, determined and certified by the Committee pursuant to Section 2(a) above. As used in this Agreement, the term "**Competitive Activity**" shall mean and refer to: any person or entity (including their successors (including any successor(s) that results from any business combination, sale or merger), assigns and transferees, whether by operation of law or otherwise) that, whether on the Retirement Date or at any time within the Restricted Period, derives more than fifty percent of its revenues from one or more non-urban acute care hospitals (and associated outpatient healthcare facilities). Nothing in this subsection (g) shall prohibit the Recipient's ownership of stock in any publicly held company (other than the Company) listed on a national securities exchange or whose shares of stock are regularly traded in the over the counter market as long as such holding at no time exceeds two percent (2%) of the total outstanding stock of such company.

(h) ***Definitions.*** For purposes of this Agreement, the following terms shall have the meanings indicated:

(i) ***"409A Change in Control"*** means an event which constitutes a "change in the ownership" of the Company, a "change in effective control" of the Company, or a "change in the ownership of a substantial portion of the assets" of the Company, each as defined under Treasury Regulations Section 1.409A-3(i)(5).

(ii) ***"Delivery Date"*** means the date on which any portion of the RSUs subject to this Agreement vest pursuant to this Section 2. Notwithstanding the foregoing, in the event the RSUs subject to this Agreement become vested upon an event which constitutes a "change in the ownership" of the Company, a "change in effective control" of the Company, or a "change in the ownership of a substantial portion of the assets" of the Company under Treasury Regulations Section 1.409A-3(i)(5), Delivery Date shall mean the date on or after such 409A Change in Control on which the Recipient has a Separation from Service, provided that such Separation from Service occurs within 24 months following such 409A Change in Control, or the date on which the RSUs subject to this Agreement would have vested pursuant to Sections 2(b), 2(c) or 2(d) in the absence of a 409A Change in Control occurring, whichever occurs earliest.

(iii) ***"Disability"*** means, solely for purposes of this Agreement and notwithstanding any provision in the Plan to the contrary, a medically determinable physical or mental impairment resulting in the Recipient's inability to perform the duties of his or her position or any substantially similar position, where such impairment can be expected to result in death or can be expected to last for a continuous period of not less than six months.

(iv) "***Non-Vested RSUs***" means any portion of the RSUs subject to this Agreement that have not become vested pursuant to this Section 2.

(v) ***"Separation from Service"*** means the voluntary or involuntary separation from service with the Service Recipient, determined in a manner consistent with Section 409A of the Code and the Treasury Regulations thereunder.

(vi) "***Service Recipient***" means the person or entity for whom the services resulting in the grant of the RSUs were performed, and with respect to whom the legally binding right to the Award arises, and all persons with whom such person would be considered a single employer under Section 414(b) of the Code (employees of a controlled group of corporations), and all persons with whom such person would be considered a single employer under Section 414(c) of the Code (employees of partnerships, proprietorships, or other entities under common control).

(vii) "***Specified Employee***" means any Recipient who, at the time of his or her Separation from Service, is a "key employee", within the meaning of Section 416(i) of the Code, of any Service Recipient the shares of which are publicly traded on an established securities market or otherwise, determined in accordance with Section 409A of the Code.

(viii) "***Vested RSUs***" means any portion of the RSUs subject to this Agreement that are and have become vested pursuant to this Section 2.

3. ***Forfeiture of RSUs.*** *Except as otherwise provided in Section 2, if the Recipient's Continuous Service is terminated prior to the Vesting Date, the RSUs shall be forfeited immediately upon such termination of Continuous Service without any payment to the Recipient.*
Settlement of the RSUs.

4. Settlement of the RSUs.

(a) ***Medium of Payment.*** If the Percentage Payable per RSU, determined in accordance with Section 2, is less than or equal to 100%, the Vested RSUs shall be settled in a number of Shares equal to the number of Vested RSUs, multiplied by the Percentage Payable per RSU. If the Percentage Payable per RSU is greater than 100%, the Vested RSUs shall be settled in (i) a number of Shares equal to the number of Vested RSUs, multiplied by 100%, plus (ii) cash equal to the Fair Market Value of a Share on the date the Committee certifies the level of Performance Goals achieved, multiplied by the portion of the Percentage Payable per RSU that exceeds 100%, multiplied by the number of Vested RSUs. Notwithstanding the foregoing, if the RSUs become vested due to the Recipient's death or Disability, the Fair Market Value of a Share on the date of the Recipient's death or Disability, as applicable, shall be used to calculate any cash payment. Furthermore, if the RSUs become vested on a 409A Change in Control pursuant to Section 2(e), the price paid per share in connection with such 409A Change in Control shall be used to calculate any cash payment. If the RSUs become vested on the Recipient's termination of Continuous Service following a 409A Change in Control pursuant to Section 2(e), the Fair Market Value of a Share on the date of the Recipient's termination of Continuous Service shall be used to calculate any cash payment.

(b) ***Payment.*** Except as provided in Subsection (d) below, the Company shall deliver to the Recipient or in the event of the Recipient's death, to the beneficiary or beneficiaries designated by the Recipient, or if the Recipient has not so designated any beneficiary(ies), or no designated beneficiary survives the Recipient, to the personal representative of the Recipient's estate, Shares and, if applicable, cash as provided in Section 4(a), on, or as soon as administratively practicable after, the Delivery Date, but in no event more than sixty (60) days thereafter. Notwithstanding the foregoing, in the event there is a 409A Change in Control on or before the date on which the Company would otherwise deliver Shares pursuant to this Section 4(b), the Company may, in lieu of delivering Shares, deliver the consideration (whether stock, cash or other securities or property) received in the 409A Change in Control transaction by holders of Shares, or such other consideration as determined by the Committee in its sole discretion, equal to the Fair Market Value of the per Share consideration received by holders of Shares in the applicable transaction, multiplied by the number of Vested RSUs that were deliverable pursuant to this Section 4. The determination of such substantial equality of Fair Market Value of consideration shall be made by the Committee in its sole discretion and its determination shall be conclusive and binding.

(c) ***Distribution to Specified Employees.*** Notwithstanding the foregoing, if the Recipient is a Specified Employee, then no payments otherwise required to be made under this Agreement on account of the Recipient's Separation from Service shall be made before the date that is six (6) months after the date of the Recipient's Separation from Service or, if earlier, the date of the Recipient's death if such deferral is required to comply with Section 409A of the Code.

(d) ***Deferred Distribution.*** Notwithstanding any other provision, the Recipient may elect pursuant to the LifePoint Hospitals Deferred Compensation Plan (the "NQDC Plan") to defer settlement of the portion of Non-Vested RSUs to be settled in Shares until a date or event other than the Delivery Date, but only to the extent allowed by the Company and subject to the terms and conditions of the NQDC Plan, including but not limited to those provisions governing deferral elections and the timing of such deferral elections. The portion of Non-Vested RSUs subject to a valid deferral election by the Recipient under the NQDC Plan shall be distributed according to the terms of the NQDC Plan, but otherwise shall continue to be subject to the terms of this Agreement, the Plan, and the deferral election form. The portion of Non-Vested RSUs to be settled in cash if the Percentage Payable is greater than 100% shall be distributed according to the terms of this Agreement and the Plan and settlement of such portion may not be deferred pursuant to this Subsection and the NQDC Plan.

5. ***Rights with Respect to RSUs.***

(a) ***No Rights as Shareholder Until Delivery.*** Except as otherwise provided in this Section 5, the Recipient shall not have any rights, benefits or entitlements with respect to Shares corresponding to the RSUs unless and until those Shares are delivered to the Recipient (and thus shall have no voting rights, or rights to receive any dividend declared, before those Shares are so delivered). On or after delivery, the Recipient shall have, with respect to the Shares delivered, all of the rights of a holder of Shares granted pursuant to the articles of incorporation and other governing instruments of the Company, or as otherwise available at law.

(b) ***Adjustments to RSUs.*** If at any time while this Agreement is in effect and before the RSUs have been settled, there shall be any increase or decrease in the number of issued and outstanding Shares of the Company through the declaration of a stock dividend or through any recapitalization resulting in a stock split-up, combination or exchange of such Shares, then the RSUs subject to this Agreement shall be adjusted in the same manner as the outstanding Shares of the Company. If any such adjustment shall result in a fractional RSU, such fraction shall be disregarded.

(c) ***No Restriction on Certain Transactions.*** Notwithstanding any term or provision of this Agreement to the contrary, the existence of this Agreement, or of any outstanding RSUs awarded hereunder, shall not affect in any manner the right, power or authority of the Company or any Related Entity to make, authorize or consummate: (i) any or all adjustments, recapitalizations, reorganizations or other changes in the Company's or any Related Entity's capital structure or its business; (ii) any merger, consolidation or similar transaction by or of the Company or any Related Entity; (iii) any offer, issue or sale by the Company or any Related Entity of any capital stock of the Company or any Related Entity, including any equity or debt securities, or preferred or preference stock that would rank prior to or on parity with the Shares represented by the RSUs and/or that would include, have or possess other rights, benefits and/or preferences superior to those that such Shares include, have or possess, or any warrants, options or rights with respect to any of the foregoing; (iv) the dissolution or liquidation of the Company or any Related Entity; (v) any sale, transfer or assignment of all or any part of the stock, assets or business of the Company or any Related Entity; or (vi) any other corporate transaction, act or proceeding (whether of a similar character or otherwise).

(d) ***Dividend Equivalents.*** During the term of this Agreement, the Recipient shall have the right to receive distributions (the "**Dividend Equivalents**") from the Company equal to any dividends or other distributions that would have been distributed to the Recipient if each RSU was instead an issued and outstanding Share owned by the Recipient. Dividend Equivalents payable with respect to the RSUs subject to this Agreement shall be subject to the following terms and conditions: (i) Dividend Equivalents payable with respect to the RSUs subject to this Agreement shall be paid on the date the RSUs to which such Dividend Equivalents relate are settled under Section 4 hereof, with such Dividend Equivalents to be accumulated, without interest, by the Company (the "**Accumulated Dividend Equivalents**"), (ii) all Accumulated Dividend Equivalents payable with respect to the RSUs subject to this Agreement shall be paid in cash, reduced by any applicable withholding taxes, and (ii) any Accumulated Dividend Equivalents with respect to the RSUs subject to this Agreement shall be forfeited and all rights of the Recipient to such Accumulated Dividend Equivalents shall terminate, without further obligation on the part of the Company, unless the portion of the RSUs subject to this Agreement to which such Accumulated Dividend Equivalents relate become Vested RSUs pursuant to Section 2 hereof. Each Dividend Equivalent shall be treated as a separate payment for purposes of Section 409A of the Code.

6. ***Transferability***. The RSUs are not transferable unless and until the Shares have been delivered to the Recipient in settlement of the RSUs in accordance with this Agreement, otherwise than by will or under the applicable laws of descent and distribution. The terms of this Agreement shall be binding upon the executors, administrators, heirs, successors and assigns of the Recipient. Except as otherwise permitted pursuant to the first sentence of this Section, any attempt to effect a Transfer of any RSUs prior to the date on which the Shares have been delivered to the Recipient in settlement of the RSUs shall be void *ab initio*. For purposes of this Agreement, "Transfer" shall mean any sale, transfer, encumbrance, gift, donation, assignment, pledge, hypothecation, or other disposition, whether similar or dissimilar to those previously enumerated, whether voluntary or involuntary, and including, but not limited to, any disposition by operation of law, by court order, by judicial process, or by foreclosure, levy or attachment.

7. ***Tax Matters.***

(a) ***Withholding.*** Any minimum tax withholding obligation of the Company arising in connection with this Award, and/or the lapse of restrictions with respect hereto, shall, to the extent permitted by law, be satisfied by the retention of cash and/or Shares issuable pursuant to this Award that have a then-current Fair Market Value equal to the amount of any minimum federal, state or local taxes of any kind required by law to be withheld with respect to this Award. If the retention of Shares described in the foregoing sentence is not permitted by law, as a condition to the Company's obligations with respect to the RSUs (including, without limitation, any obligation to deliver any Shares) hereunder, the Recipient shall make arrangements satisfactory to the Company to pay to the Company any federal, state or local taxes of any kind required to be withheld with respect to the vesting or delivery of Shares corresponding to such RSUs.

(b) ***Recipient's Responsibilities for Tax Consequences.*** The tax consequences to the Recipient (including without limitation federal, state, local and foreign income tax consequences) with respect to the RSUs (including without limitation the grant, vesting and/or delivery thereof) are the sole responsibility of the Recipient. The Recipient shall consult with his or her own personal accountant(s) and/or tax advisor(s) regarding these matters and the Recipient's filing, withholding and payment (or tax liability) obligations.

8. ***Amendment, Modification & Assignment.*** This Agreement may only be modified or amended in a writing signed by the parties hereto. No promises, assurances, commitments, agreements, undertakings or representations, whether oral, written, electronic or otherwise, and whether express or implied, with respect to the subject matter hereof, have been made by either party which are not set forth expressly in this Agreement. This Agreement (and Recipient's rights hereunder) may not be assigned, and the obligations of Recipient hereunder may not be delegated, in whole or in part. The rights and obligations created hereunder shall be binding on the Recipient and his heirs and legal representatives and on the successors and assigns of the Company.

9. ***Complete Agreement.*** This Agreement (together with those agreements and documents expressly referred to herein, for the purposes referred to herein) embody the complete and entire agreement and understanding between the parties with respect to the subject matter hereof, and supersede any and all prior promises, assurances, commitments, agreements, undertakings or representations, whether oral, written, electronic or otherwise, and whether express or implied, which may relate to the subject matter hereof in any way.

10. ***Miscellaneous.***

(a) ***No Right to (Continued) Employment or Service.*** This Agreement and the grant of RSUs hereunder shall not confer, or be construed to confer, upon the Recipient any right to employment or service, or continued employment or service, with the Company or any Related Entity.

(b) ***No Limit on Other Compensation Arrangements.*** Nothing contained in this Agreement shall preclude the Company or any Related Entity from adopting or continuing in effect other or additional compensation plans, agreements or arrangements, and any such plans, agreements and arrangements may be either generally applicable or applicable only in specific cases or to specific persons.

(c) ***Severability.*** If any term or provision of this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or under any applicable law, rule or regulation, then such provision shall be construed or deemed amended to conform to applicable law (or if such provision cannot be so construed or deemed amended without materially altering the purpose or intent of this Agreement and the grant of RSUs hereunder, such provision shall be stricken as to such jurisdiction and the remainder of this Agreement and the award hereunder shall remain in full force and effect).

(d) ***No Trust or Fund Created.*** Neither this Agreement nor the grant of RSUs hereunder shall create or be construed to create a trust or separate fund of any kind or a fiduciary relationship between the Company or any Related Entity and the Recipient or any other person. To the extent that the Recipient or any other person acquires a right to receive payments from the Company or any Related Entity pursuant to this Agreement, such right shall be no greater than the right of any unsecured general creditor of the Company.

(e) ***Law Governing.*** This Agreement shall be governed by and construed and enforced in accordance with the internal laws of the State of Delaware (without reference to the conflict of laws rules or principles thereof).

(f) ***Interpretation.*** This award of RSUs is subject to all of the terms, provisions and restrictions of this Agreement and the Plan. All decisions or interpretations of the Board or the Committee upon any questions arising under this Agreement or the Plan are binding, conclusive and final.

(g) ***Headings.*** Section, paragraph and other headings and captions are provided solely as a convenience to facilitate reference. Such headings and captions shall not be deemed in any way material or relevant to the construction, meaning or interpretation of this Agreement or any term or provision hereof.

(h) ***Notices.*** Any notice under this Agreement shall be in writing and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, registered, postage prepaid, and addressed, in the case of the Company, to the Company's General Counsel at 330 Seven Springs Way, Brentwood, Tennessee 37207, or if the Company should move its principal office, to such principal office, and, in the case of the Recipient, to the Recipient's last permanent address as shown on the Company's records, subject to the right of either party to designate some other address at any time hereafter in a notice satisfying the requirements of this Section.

(i) ***Compliance with Section 409A***

(i) ***General.*** It is the intention of both the Company and the Recipient that the benefits and rights to which the Recipient could be entitled pursuant to this Agreement comply with Section 409A of the Code and the Treasury Regulations and other guidance promulgated or issued thereunder ("**Section 409A**"), to the extent that the requirements of Section 409A are applicable thereto, and the provisions of this Agreement shall be construed in a manner consistent with that intention. If the Recipient or the Company believes, at any time, that any such benefit or right that is subject to Section 409A does not so comply, it shall promptly advise the other and shall negotiate reasonably and in good faith to amend the terms of such benefits and rights such that they comply with Section 409A (with the most limited possible economic effect on the Recipient and on the Company).

(ii) ***No Representations as to Section 409A Compliance.*** Notwithstanding the foregoing, the Company does not make any representation to the Recipient that the shares of RSUs and the Dividend Equivalents, if any, awarded pursuant to this Agreement are exempt from, or satisfy, the requirements of Section 409A, and the Company shall have no liability or other obligation to indemnify or hold harmless the Recipient or any Beneficiary for any tax, additional tax, interest or penalties that the Recipient or any Beneficiary may incur in the event that any provision of this Agreement, or any amendment or modification thereof or any other action taken with respect thereto is deemed to violate any of the requirements of Section 409A.

(iii) ***No Acceleration of Payments.*** Neither the Company nor the Recipient, individually or in combination, may accelerate any payment or benefit that is subject to Section 409A, except in compliance with Section 409A and the provisions of this Agreement, and no amount that is subject to Section 409A shall be paid prior to the earliest date on which it may be paid without violating Section 409A.

(iv) ***Treatment of Each Installment as a Separate Payment.*** For purposes of applying the provisions of Section 409A to this Agreement, each separately identified amount to which the Recipient is entitled under this Agreement shall be treated as a separate payment. In addition, to the extent permissible under Section 409A, any series of installment payments under this Agreement shall be treated as a right to a series of separate payments.

(j) ***Non-Waiver of Breach.*** The waiver by any party hereto of the other party's prompt and complete performance, or breach or violation, of any term or provision of this Agreement shall be effected solely in a writing signed by such party, and shall not operate nor be construed as a waiver of any subsequent breach or violation, and the waiver by any party hereto to exercise any right or remedy which he or it may possess shall not operate nor be construed as the waiver of such right or remedy by such party, or as a bar to the exercise of such right or remedy by such party, upon the occurrence of any subsequent breach or violation.

(k) ***Clawback of Benefits.*** The Committee shall have full authority to implement any policies and procedures that it determines to be necessary or appropriate to comply with applicable securities laws or other laws, including, without limitation, Section 10D of the Exchange Act and any rules promulgated thereunder, including without limitation, including in this Agreement, or amending any this Agreement, without the consent of the Recipient, to include language for the clawback (recapture) by the Company of any benefits under this Agreement that the Committee deems necessary or appropriate to comply with that statutory provision and those rules.

EXHIBIT 12.1

LIFEPOINT HOSPITALS, INC.
COMPUTATIONS OF RATIOS OF EARNINGS TO FIXED CHARGES
(Unaudited)

(Dollars in Millions)

	Years Ended December 31,				
	2014	2013	2012	2011	2010
EARNINGS					
Income from continuing operations before income taxes	$203.0	$211.5	$244.1	$263.3	$241.1
Fixed charges, exclusive of capitalized interest	138.7	110.6	114.0	119.3	118.1
TOTAL EARNINGS	$341.7	$322.1	$358.1	$382.6	$359.2
FIXED CHARGES					
Interest charged to expense[(a)]	123.5	98.4	102.5	109.2	109.0
Interest portion of rental expense	15.2	12.2	11.5	10.1	9.1
Fixed charges, exclusive of capitalized interest	138.7	110.6	114.0	119.3	118.1
Capitalized interest	1.0	1.4	2.3	2.0	0.8
TOTAL FIXED CHARGES	$139.7	$112.0	$116.3	$121.3	$118.9
RATIO OF EARNINGS TO FIXED CHARGES	2.45	2.88	3.08	3.15	3.02

(a) excluding interest income

Exhibit 21.1

Subsidiaries of LifePoint Hospitals, Inc.

Name of Entity	Location of Incorporation or Organization
Acquisition Bell Hospital, LLC	Michigan
America Management Companies, LLC	Delaware
AMG — Crockett, LLC	Delaware
AMG — Hillside, LLC	Delaware
AMG — Livingston, LLC	Delaware
AMG — Logan, LLC	Delaware
AMG — Southern Tennessee, LLC	Delaware
AMG — Trinity, LLC	Delaware
Andalusia Physician Practices, LLC	Delaware
Ashland Physician Services, LLC	Delaware
Ashley Valley Medical Center, LLC	Delaware
Ashley Valley Physician Practice, LLC	Delaware
Athens Physicians Practice, LLC	Delaware
Athens Regional Medical Center, LLC	Delaware
Athens Surgery Center, LLC	Delaware
Athens Surgery Center Partner, LLC	Delaware
Barrow Medical Center, LLC	Delaware
Bartow General Partner, LLC	Delaware
Bartow Healthcare System, Ltd.	Florida
Bartow Memorial Limited Partner, LLC	Delaware
Bell JV, LLC	Delaware
Bell Physician Practices, Inc.	Michigan
Bolivar Physician Practices, LLC	Delaware
Bourbon Community Hospital, LLC	Delaware
Bourbon Physician Practice, LLC	Delaware
Brim Hospitals, Inc.	Oregon
Buffalo Trace Radiation Oncology Associates, LLC	Kentucky
Care Health Company, Inc.	Washington
Castleview Hospital, LLC	Delaware
Castleview Medical, LLC	Delaware
Castleview Physician Practice, LLC	Delaware
Clark Regional Physician Practices, LLC	Delaware
Clinch Professional Physician Services, LLC	Delaware
Clinch Valley Medical Center, Inc.	Virginia
Clinch Valley Physicians Associates, LLC	Virginia
Clinch Valley Pulmonology, LLC	Virginia
Clinch Valley Urology, LLC	Virginia
Colorado Plains Physician Practices, LLC	Delaware
Community-Based Services, LLC	Delaware
Community Hospital of Andalusia, Inc.	Alabama
Community Medical, LLC	Delaware
Crockett Hospital, LLC	Delaware
Crockett PHO, LLC	Delaware
Danville Diagnostic Imaging Center, LLC	Delaware
Danville Physician Practices, LLC	Delaware
Danville Regional Medical Center, LLC	Delaware
Danville Regional Medical Center School of Health Professions, LLC	Delaware
DLP Cardiac Partners, LLC	Delaware

Name of Entity	Location of Incorporation or Organization
DLP Conemaugh Holding Company, LLC	Delaware
DLP Conemaugh JV, LLC	Delaware
DLP Conemaugh Memorial Medical Center, LLC	Delaware
DLP Conemaugh Meyersdale Medical Center, LLC	Delaware
DLP Conemaugh Miners Medical Center, LLC	Delaware
DLP Conemaugh Physician Practices, LLC	Delaware
DLP Haywood Regional Medical Center, LLC	Delaware
DLP Harris JV, LLC	Delaware
DLP Harris Regional Hospital, LLC	Delaware
DLP Healthcare, LLC	Delaware
DLP Maria Parham Medical Center, LLC	Delaware
DLP Maria Parham Physician Practices, LLC	Delaware
DLP Marquette General Hospital, LLC	Michigan
DLP Marquette Health Plan, LLC	Delaware
DLP Marquette Holding Company, LLC	Delaware
DLP Marquette JV, LLC	Delaware
DLP Marquette Physician Practices, Inc.	Michigan
DLP Partner, LLC	Delaware
DLP Partner Conemaugh, LLC	Delaware
DLP Partner Marquette, LLC	Delaware
DLP Partner MedWest, LLC	Delaware
DLP Partner Twin County, LLC	Delaware
DLP Partner Wilson Rutherford, LLC	Delaware
DLP Person Memorial Hospital, LLC	Delaware
DLP Person Physician Practices, LLC	Delaware
DLP Rutherford Regional Health System, LLC	Delaware
DLP Rutherford Physician Practices, LLC	Delaware
DLP Swain County Hospital, LLC	Delaware
DLP Twin County Holding Company, LLC	Delaware
DLP Twin County Physician Practices, LLC	Delaware
DLP Twin County Regional Healthcare, LLC	Delaware
DLP Western Carolina Physician Practices, LLC	Delaware
DLP WilMed Nursing Care and Rehabilitation Center, LLC	Delaware
DLP Wilson Holding Company, LLC	Delaware
DLP Wilson Medical Center, LLC	Delaware
DLP Wilson Physician Practices, LLC	Delaware
Dodge City Healthcare Group, LLC	Kansas
Dodge City Healthcare Partner, Inc.	Kansas
Fauquier Holding Company, LLC	Delaware
Fauquier Long-Term Care, LLC	Delaware
Fauquier Medical Center, LLC	Delaware
Fauquier Partner, LLC	Delaware
Fauquier Physician Practices, LLC	Delaware
Georgetown Community Hospital, LLC	Delaware
Georgetown Rehabilitation, LLC	Delaware
Guyan Valley Hospital, LLC	Delaware
Halstead Hospital, LLC	Delaware
Havasu Regional Medical Center, LLC	Delaware
HCK Logan Memorial, LLC	Delaware
HDP Andalusia, LLC	Delaware
HDP Georgetown, LLC	Delaware

Name of Entity	Location of Incorporation or Organization
Hillside Hospital, LLC	Delaware
Historic LifePoint Hospitals, Inc.	Delaware
HRMC, LLC	Delaware
HSC Manager, LLC	Delaware
HSCGP, LLC	Delaware
HST Physician Practice, LLC	Delaware
HTI Georgetown, LLC	Delaware
HTI PineLake, LLC	Delaware
Integrated Physician Services, LLC	Delaware
Kansas Healthcare Management Company, Inc.	Kansas
Kansas Healthcare Management Services, LLC	Kansas
Kentucky Hospital, LLC	Delaware
Kentucky Medserv, LLC	Delaware
Kentucky MSO, LLC	Delaware
Kentucky Physician Services, Inc.	Kentucky
Lake Cumberland Cardiology Associates, L LC	Delaware
Lake Cumberland Physician Practices, LLC	Delaware
Lake Cumberland Regional Hospital, LLC	Delaware
Lake Cumberland Regional Physician Hospital Organization, LLC	Delaware
Lake Cumberland Surgery Center, LP	Delaware
Lakeland Community Hospital, LLC	Delaware
Lakeland Physician Practices, LLC	Delaware
Lamar Surgery Center, LP	Delaware
Lander Valley Physician Practices, LLC	Delaware
Las Cruces Cardiology Group, LLC	Delaware
Las Cruces Endoscopy, LLC	Delaware
Las Cruces Endoscopy Partner, LLC	Delaware
Las Cruces Physician Practices, LLC	Delaware
LCMC MRI, LLC	Delaware
LCMC PET, LLC	Delaware
LHSC, LLC	Delaware
LifePoint Acquisition Corp.	Delaware
LifePoint Asset Management Company, Inc.	Delaware
LifePoint Billing Services, LLC	Delaware
LifePoint Corporate Services, General Partnership	Delaware
LifePoint CSLP, LLC	Delaware
LifePoint Holdings 2, LLC	Delaware
LifePoint Hospitals Holdings, Inc.	Delaware
LifePoint Medical Group — Hillside, Inc.	Tennessee
LifePoint of GAGP, LLC	Delaware
LifePoint of Georgia, Limited Partnership	Delaware
LifePoint of Kentucky, LLC	Delaware
LifePoint of Lake Cumberland, LLC	Delaware
LifePoint PSO, LLC	Delaware
LifePoint RC, Inc.	Delaware
LifePoint VA Holdings, Inc.	Delaware
LifePoint WV Holdings, Inc.	Delaware
Livingston Regional Hospital, LLC	Delaware
Logan General Hospital, LLC	Delaware
Logan Healthcare Partner, LLC	Delaware
Logan Medical, LLC	Delaware

Name of Entity	Location of Incorporation or Organization
Logan Memorial Hospital, LLC	Delaware
Logan Oncology Care Associates, LLC	West Virginia
Logan Physician Practice, LLC	Delaware
Lohman Endoscopy Center, LLC	New Mexico
Los Alamos Physician Practices, LLC	Delaware
Martinsville Physician Practices, LLC	Delaware
Meadowview Physician Practice, LLC	Delaware
Meadowview Regional Medical Center, LLC	Delaware
Meadowview Rights, LLC	Delaware
Memorial Hospital of Martinsville & Henry CountyAmbulatory Surgery Center, LLC	Virginia
Memorial Prompt Care, LLC	Delaware
Mercy Physician Practices, LLC	Delaware
Mexia Principal Healthcare Limited Partnership	Texas
Mexia-Principal, Inc.	Texas
Minden Physician Practices, LLC	Delaware
Nason Medical Center, LLC	Delaware
Nason Physician Practices, LLC	Delaware
Northeastern Nevada Physician Practices, LLC	Delaware
Northwest Medical Center-Winfield, LLC	Delaware
Norton Partner, LLC	Delaware
NWMC – Winfield Anesthesia Physicians, LLC	Delaware
NWMC – Winfield Hospitalist Physicians, LLC	Delaware
NWMC – Winfield Physician Practices, LLC	Delaware
OmniPoint Surgical Associates, LLC	Delaware
Ontonagon Community Health Center, Inc.	Michigan
Opelousas Imaging Center Partner, LLC	Delaware
Opelousas PET/CT Imaging Center, LLC	Delaware
Orthopedics of Southwest Virginia, LLC	Virginia
Palestine-Principal G.P., Inc.	Texas
Palestine Principal Healthcare Limited Partnership	Texas
PH Copper Country Apothecaries, LLC	Delaware
PHC-Ashland, L.P.	Pennsylvania
PHC-Aviation, Inc.	Tennessee
PHC-Belle Glade, Inc.	Florida
PHC-Charlestown, L.P.	Indiana
PHC-Cleveland, Inc.	Mississippi
PHC-Doctors' Hospital, Inc.	Louisiana
PHC-Elko, Inc.	Nevada
PHC-Fort Mohave, Inc.	Arizona
PHC-Fort Morgan, Inc.	Colorado
PHC Hospitals, LLC	Delaware
PHC-Indiana, Inc.	Indiana
PHC-Knox, Inc.	Nevada
PHC-Lake Havasu, Inc.	Arizona
PHC-Lakewood, Inc.	Louisiana
PHC-Las Cruces, Inc.	New Mexico
PHC-Los Alamos, Inc.	New Mexico
PHC-Louisiana, Inc.	Louisiana
PHC-Martinsville, Inc.	Virginia
PHC-Minden G.P., Inc.	Louisiana
PHC-Minden, L.P.	Louisiana

Name of Entity	Location of Incorporation or Organization
PHC-Morgan City, L.P.	Louisiana
PHC-Morgan Lake, Inc.	Louisiana
PHC-Opelousas, L.P.	Louisiana
PHC-Palestine, Inc.	Nevada
PHC-Selma, LLC	Delaware
PHC-Tennessee, Inc.	Tennessee
Piedmont Partner, LLC	Delaware
PineLake Physician Practice, LLC	Delaware
PineLake Regional Hospital, LLC	Delaware
Point of Life Indemnity, Ltd.	Cayman Islands
Poitras Practice, LLC	Delaware
Portage Holding Company, LLC	Delaware
Portage Hospital, LLC	Michigan
Portage JV, LLC	Delaware
Portage Partner, LLC	Delaware
Portage Physician Practices, Inc.	Michigan
PRHC-Alabama, LLC	Delaware
PRHC-Ennis G.P., Inc.	Texas
PRHC-Ennis, L.P.	Texas
Principal Hospital Company of Nevada, Inc.	Nevada
Principal Knox, L.L.C.	Delaware
Principal Knox, L.P.	Delaware
Principal-Needles, Inc.	Tennessee
Province Healthcare Company	Delaware
Putnam Ambulatory Surgery Center, LLC	Delaware
Putnam Community Medical Center, LLC	Delaware
Putnam Physician Practices, LLC	Delaware
R. Kendall Brown Practice, LLC	Delaware
Raleigh General Hospital, LLC	West Virginia
RHN Scott Memorial Hospital, LLC	Delaware
RHN Scott Physician Practices, LLC	Delaware
River Parishes Holdings, LLC	Delaware
River Parishes Hospital, LLC	Delaware
River Parishes Partner, LLC	Delaware
River Parishes Physician Practices, LLC	Delaware
Riverton Memorial Hospital, LLC	Delaware
Riverton Oncology Practice, LLC	Delaware
Riverton Physician Practices, LLC	Delaware
Riverview Medical Center, LLC	Delaware
Riverview Physician Practices, LLC	Delaware
Rockdale Clinically Integrated Medical Care Organization, LLC	Delaware
Rockdale Hospital, LLC	Delaware
Rockdale Physician Practices, LLC	Delaware
Russellville Hospital, LLC	Delaware
Russellville Physician Practices, LLC	Delaware
Select Healthcare, LLC	Delaware
Selma Diagnostic Imaging, LLC	Delaware
Siletchnik Practice, LLC	Delaware
Smith County Memorial Hospital, LLC	Delaware
Somerset Surgery Partner, LLC	Delaware
Southern Tennessee EMS, LLC	Delaware

Name of Entity	Location of Incorporation or Organization
Southern Tennessee Medical Center, LLC	Delaware
Southern Tennessee PHO, LLC	Delaware
Spring View Hospital, LLC	Delaware
Spring View Physician Practices, LLC	Delaware
Springhill Medical Center, LLC	Delaware
SST Community Health, L.L.C.	Tennessee
Starke Physician Practices, LLC	Delaware
Sumner Physician Practices, LLC	Delaware
Sumner Real Estate Holdings, LLC	Delaware
Sumner Regional Medical Center, LLC	Delaware
Texas Specialty Physicians	Texas
The LifePoint Community Foundation	Delaware
The MRI Center of Northwest Alabama, LLC	Delaware
The Regional Health Network of Kentucky and Southern Indiana, LLC	Delaware
THM Physician Practice, LLC	Delaware
Trousdale Medical Center, LLC	Delaware
Trousdale Physician Practices, LLC	Delaware
Two Rivers Physician Practices, LLC	Delaware
Valley View Physician Practices, LLC	Delaware
Vaughan Physician Practices, LLC	Delaware
Vaughan Regional Medical Center, LLC	Delaware
Ville Platte Medical Center, LLC	Delaware
West Virginia Management Service Organization, Inc.	West Virginia
Western Plains Physician Practices, LLC	Delaware
Western Plains Regional Hospital, LLC	Delaware
Woodford Hospital, LLC	Delaware
Woods Memorial Hospital, LLC	Delaware
Wythe County Community Hospital, LLC	Delaware
Wythe County Physician Practices, LLC	Delaware
Zone, Incorporated	West Virginia

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Form S-8 (No. 333-190219) pertaining to the LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan;

(2) Form S-8 (No. 333-168476) pertaining to the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, and LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock Incentive Compensation Plan;

(3) Form S-8 (No. 333-159233) pertaining to the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, LifePoint Hospitals, Inc. Employee Stock Purchase Plan, LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, LifePoint Hospitals, Inc. Retirement Plan, and LifePoint Hospitals, Inc. Amended and Restated Outside Director's Stock and Incentive Compensation Plan;

(4) Form S-4 (No. 333-174014), as amended, pertaining to the $400,000,000 6.625% Senior Notes due 2020;

(5) Form S-4 (No. 333-197380), as amended, pertaining to the $1,100,000,000 5.5% Senior Notes due 2021; and

(6) Form S-8 (No. 333-182932) pertaining to the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan and to the LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan;

of our reports dated February 12, 2015, with respect to the consolidated financial statements of LifePoint Hospitals, Inc. and the effectiveness of internal control over financial reporting of LifePoint Hospitals, Inc., included in this Annual Report (Form 10-K) of LifePoint Hospitals, Inc. for the year ended December 31, 2014.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 12, 2015

EXHIBIT 31.1

LIFEPOINT HOSPITALS, INC.

CERTIFICATION

I, William F. Carpenter III, certify that:

1. I have reviewed this annual report on Form 10-K of LifePoint Hospitals, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and
   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ William F. Carpenter III

William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date: February 12, 2015

EXHIBIT 31.2

LIFEPOINT HOSPITALS, INC.

CERTIFICATION

I, Leif M. Murphy, certify that:

1. I have reviewed this annual report on Form 10-K of LifePoint Hospitals, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and
   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Leif M. Murphy
Leif M. Murphy
Executive Vice President and Chief Financial Officer

Date: February 12, 2015

EXHIBIT 32.1

LIFEPOINT HOSPITALS, INC.

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Report of LifePoint Hospitals, Inc. (the "Company") on Form 10-K for the year ended December 31, 2014, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, William F. Carpenter III, Chief Executive Officer and Chairman of the Board of Directors of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) To the best of my knowledge information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ William F. Carpenter III
William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date: February 12, 2015

EXHIBIT 32.2

LIFEPOINT HOSPITALS, INC.

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Report of LifePoint Hospitals, Inc. (the "Company") on Form 10-K for the year ended December 31, 2014, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Leif M. Murphy, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) To the best of my knowledge information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Leif M. Murphy
Leif M. Murphy
Executive Vice President and Chief Financial Officer

Date: February 12, 2015

Tab 15

Attachment C
Contribution to the Orderly Development of Health Care – 2

Letters of Support

Additional letters to be submitted separately

August 9, 2015

Melanie M. Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Dear Ms. Hill:

I am writing this letter of support for the expansion of emergency department services at Sumner Station, located at 225 Big Station Camp Blvd., in Gallatin, TN. As a mother of two children and a daughter of two elderly parents, I feel this is a tremendous need for our community.

I have lived in the Big Station Camp, Douglas Bend and Cages Bend area of Sumner County for a total of twenty-four years ranging from 1977 to now. During that time, I have witnessed the rapid growth in our community from new schools, new housing, and additional fire departments. These wonderful additions have increased the amount of traffic and travel time we spend on neighborhood roads to get to our destination. This increase of traffic and travel time is a concern for a mom who has a child with a food allergy and a daughter of two elderly parents in this community.

On October 18, 2014, our son obtained a head injury from an incident on playground equipment. We rushed him to the emergency department of Sumner Regional Medical Center in Gallatin, TN. While we were there, we received excellent medical services. My son experienced expedited care with state-of-the-art medical equipment and expertise from a staff that showed care and concern. There is a need for this same level of medical care in my community.

As a mom, my primary goal is to provide a safe and loving environment for my children. The expansion of emergency department services at Sumner Station would provide that protection and comfort. My young son has a food allergy that if triggered could send him into anaphylactic shock. When his prescribed EpiPen is used, we would need to transport him to an emergency department immediately. The time in getting him medical attention is vital to his survival. Currently, with no traffic congestion, it takes our family 20 minutes to get to the current Sumner Regional Medical Center in Gallatin, TN and 18 minutes to get to Hendersonville Medical Center in Hendersonville, TN. With the expansion of the emergency department services at Sumner Station, our travel time would be reduced to 7 minutes. This difference in response time to give my son medical care could save his life.

As an only child of elderly parents in the community, I would find great comfort in knowing there were emergency department services at Sumner Station. When my elderly parents require treatment for falls or other ailments, Sumner Station emergency services would allow me to get them treatment by a trusted community provider.

My community needs emergency department services at Sumner Station. I urge you and the members of the Health Services and Development Agency to approve this project.

Sincerely,

Karla Beams Taylor

Karla Beams Taylor, M.Ed.
Mother, Daughter, Wife, Community Supporter, and Educator

Tab 16

Attachment C
Contribution to the Orderly Development of Health Care – 4

Physician CVs

Scott MacPherson Bradley, MD, MPH

Home	284 Charles Marx Way Palo Alto, CA 94304	Phone: (650) 380-5779 Email: smbrad@stanford.edu
Office	Division of Emergency Medicine 300 Pasteur Drive Alway Bldg., Room M121 Stanford, CA 94305	Phone: (650) 723-6576 Fax: (650) 723-0121

Current Positions

Clinical Instructor, Division of Emergency Medicine
Stanford University Hospital: Stanford, CA. 7/10 to present

Emergency Medicine Pool Physician
Kaiser Permanente Medical Center: Redwood City, CA. 6/10 to present

Education

Doctor of Medicine. University of California at Irvine, School of Medicine. Irvine, CA. May 2007

Masters of Public Health. Johns Hopkins Bloomberg School of Public Health. Baltimore, MD. May 2005

- Biostatistics, Epidemiology, Humanitarian Assistance

Bachelor of Arts. University of California at Berkeley. Berkeley, CA. May 2001

- Molecular and Cell Biology: High Honors

Post Doctoral Experience/ Residency Training:

Stanford/Kaiser Emergency Medicine Residency. Resident of Emergency Medicine, Class of 2010

Stanford University Hospital: Stanford, CA. Academic hospital

- Level 1 pediatric/adult trauma center; Pediatric Emergency Department; 50,000 annual patient visits

Santa Clara Valley Medical Center: San Jose, CA. County hospital

- Level 1 pediatric/adult trauma center; Burn center; 130,000 annual patient visits

San Francisco General Hospital: San Francisco, CA. County hospital

- Level 1 pediatric/adult trauma center; 53,000 patient visits per year

Kaiser Permanente Santa Clara Medical Center: Santa Clara, CA. Community hospital

- 60,000 patient visits per year

Professional Activities

International Emergency Medicine Fellowship, Stanford University Hospital

- Emergency Medicine Educator, Stanford University Hospital
  - Two lectures monthly to resident physicians and medical students
- Clinical Educator, Kathmandu, Nepal

- Collaboration with the Nepal Ambulance Service (NAS) in the development and teaching of Nepal's first EMT curriculum and EMS ambulance service

- Clinical Educator, Hyderabad, India
  - Collaboration with the Emergency Management Research Institute (EMRI), the largest ambulance company in India, in the development of nationwide pre-hospital care treatment protocols.
- Participant in the Professional Practice Evaluation Committee (PPEC)

Honors and Awards

Clinical Excellence in Residency; Stanford/Kaiser Senior Resident Award
Alpha Omega Alpha Honor Medical Society
Alumni Scholarship Award; Full Academic scholarship to Johns Hopkins School of Public Health

Certifications

Ultrasound Credentialed: Stanford University Hospital
Advanced Trauma Live Support
Advanced Cardiac Life Support
Pediatric Advanced Life Support
APLS (Advanced Pediatric Life Support): Currently enrolled

Licensure

Emergency Medicine Board, Written: Passed
Emergency Medicine Boards, Oral: Scheduled May 1st
California State Medical License
DEA License

Memberships

Society for Academic Emergency Medicine
American College of Emergency Physicians

Languages

Spanish: conversational

Personal Interests

International health, ultrasound, wilderness medicine.

Rock climbing, surfing, mountain biking, camping, travel, music, cuisine.

Lectures

- Severe Allergy and Anaphylaxis
- Extremity Trauma and Management
- Splinting in the Emergency Department
- Ventilation Made Easy: A Guide to Ventilators and Non-Invasive Ventilation for the Emergency Physician
- Emergency Medicine/Trauma/Pediatrics/Neurosurgery Grand Rounds at Santa Clara Valley Medical Center: Publication Review: 'Identification of children at very low risk of clinically-important brain injuries after head trauma: a prospective cohort study. Lancet 2009'
- Trauma Conference: Penetrating Thoracic Trauma and the ED Thoracotomy
- Trauma Conference: Thermal and Chemical Burns
- Severe GI Bleed: Treatment and Updates
- Emergency Medicine/ICU conference: A Case of Metformin Associated Lactic Acidosis (MALA) and review of the literature
- Pediatric Interesting Case: Pediatric Epidural Abscess: Case description and review of the literature
- Inferior and right sided MI: Review of interventions
- Common Presentations of Respiratory Distress
- Introduction to Emergency Medicine

anuscripts/Publications/Abstracts

Bradley S, Encarnacion B, Wang E. Pediatric Epidural Abscess: Case description & review of the literature. Pediatric Emergency Medicine Newsletter. November 2010

Ragunathan A, Bradley S, Mahadevan S. Epidemiology Of Road Traffic Injuries In Andhra Pradesh, India: A Prospective Analysis Raghunathan, MD. Scheduled for presentation at annual Society of Academic Emergency Medicine, 2011

Goodis J, Bradley S, Gharabaghian L, Donniger S, Crandall S, Spain D, Williams S. Sonographic Identification of Tube Thoracostomy Study (SITTS): A Novel Technique. Presented at the Western Society of Academic Emergency Medicine, 2009.

Doocy S, Rofi A, Moodie C, Spring E, Bradley S, Burnham G, and Robinson C. Tsunami Mortality in Aceh Province, Indonesia. *World Health Organization Research Bulletin (International Journal of Public Health).* 2007; 85 : 273-278.

Bradley S, Black R, and Baqui A. The Epidemiology of Acute Lower Respiratory Tract Infections in children under 5 in rural Bangladesh. (Masters thesis). Accepted by the Johns Hopkins School of Public Health, April, 2005.

Lewis B, Granich R, Courval J, Krammerer JS, Rosenblum L, McNabb S, **Bradley SM**, and Flood J. Molecular Epidemiology of Multi-drug Resistant Mycobacterium tuberculosis in the United States 1996-2000. American Public Health Association (APHA) in 2003.

Lewis B, **Bradley SM**, Granich R, and Flood J. (Surveillance and Epidemiology Section, TB control branch of the California Department of Health Services). Molecular Epidemiology of Multi-drug Resistant Mycobacterium tuberculosis in California 1996-2000. Poster presented at the meeting of the California Tuberculosis Controllers Association (CTCA) in 2001.

CME requirement: As stated by the AMA guidelines on CME (included). 60 CME credits are granted for Board certification.

Certification status:

Written boards passed

Oral boards: taken on May 1st, with results pending

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: Scott M. Bradley, MD

INSTITUTION: American Board of Emergency Medicine

REPRESENTATIVE'S NAME: Michelle.

PHONE NUMBER: 517-332-4800 ext. 381

INFORMATION VERIFIED Dr. Bradley is Board Certified effective 6/8/2011 through 12/31/2021 with certificate number 49051.

DATE/TIME: June 24, 2011, 2:45 PM

VERIFIED BY: Tammy Carter, Medical Staff Services

8207 M-5 Sawyer Brown Rd.
Nashville, TN 37221

Phone: (615) 260-8168
Email: chrissy.coleman@yahoo.com

Christine T. (Wolf) Coleman, M.D.

Education

2002-2006 Case School of Medicine Cleveland, OH

- Doctor of Medicine degree
- Alpha Omega Alpha

1998 –2002 The Ohio State University Columbus, OH

- Bachelor of Science in Molecular Genetics ; minor: history
- *Summa cum laude*, Phi Beta Kappa

Work Experience

2006-present Vanderbilt University Medical Center Nashville, TN

- Emergency Medicine residency training

2003 Case Western Reserve University Cleveland, OH

- Undergraduate Anatomy Teaching Assistant- prosections, teaching class, review sessions, grading

2002 The Ohio State University Columbus, OH

- Chemistry and biology tutor for minority student program

1999-2001 Hillebrand Nursing Home Cincinnati, OH

- Nurse Aide Assistant

Achievements

- Induction into Alpha Omega Alpha, 2006
- SAEM Excellence in Emergency Medicine Medical Student Award, 2006
- Alpha Omega Alpha Award at 2004 Irwin Lepow Medical Student Research Day for oral presentation of "Asthma care after exacerbation: the gap between guidelines and reality remains wide."
- Amici Medicinae Scholarship (half tuition for medical school) 2002-2006
- Crile Summer Research Fellowship (Case School of Medicine), 2003
- National Mortar Board Graduate School Fellowship, 2002
- OSU College of Biological Sciences Outstanding Senior Award, 2002
- Induction into Phi Beta Kappa, Ohio State University Chapter, 2002
- President's Salute to Undergraduate Academic Achievement (OSU), 2002
- Multiple undergraduate academic scholarships

Leadership

2008-present Critical Care Committee at Vanderbilt Nashville, TN

- Resident representative to institutional critical care committee; liaison between this committee and the House Staff Advisory Council

2007-present House Staff Advisory Council at Vanderbilt Nashville, TN

- Emergency Medicine program representative; liaison between graduate medical education and Emergency Medicine Residents

2002-2006 American Medical Student Association Cleveland, OH

- **Service chairperson** for 2003-4 school year, organized multiple activities
- Attended regional conference, political leadership institute

2002-2004 Emergency Medicine Interest Group Cleveland, OH

- **Co-coordinator** in 2003-2004

Research Experience

2008-present Vanderbilt Medical Center Nashville, TN

- Department of Emergency Medicine, PI: Dr. Jason Thurman
- Project: Implications of hospital wide stroke alert system

2003- 2004 Case/Metrohealth Medical Center Cleveland, OH

- Department of Emergency Medicine, PI: Dr. Rita Cydulka
- Project: Asthma care after exacerbation: the gap between guidelines and reality remains wide
- Published in **Annals of Emergency Medicine** and chosen for oral presentation at medical school research day

2000-2002 The Ohio State University Columbus, OH

- Department of Molecular Genetics, PI: Dr. Mark Muller
- Project: The relationship between DNA topoisomerase I and p53

1998- 2000 The Ohio State University Columbus, OH

- Student research assistant, Dr. Pascal Goldschmidt, Heart & Lung Institute

Publications and Presentations

Cydulka RK, Tamayo-Sarver, JH, **Wolf C**, Herrick E, Gress S. Inadequate follow up controller medications among patients with asthma who visit the emergency department. **Annals of Emergency Medicine** October 2005; 46 (4): 316-322.

Presenter: **Wolf C**. Authors: Cydulka RK, Tamayo-Sarver, JH, Wolf C, Herrick E, Gress S. Asthma care after exacerbation: the gap between guidelines and reality remains wide. **Case Lepow Medical Student Research Day**, May 2004.

Selected Volunteer Experience

2007-present Vanderbilt University Medical Center Nashville, TN

- Volunteer with medical student educational activities

2002-2005 Free Clinic Cleveland, OH

- Worked with underserved population in urban Cleveland

2003-2004 West Side Catholic Women's Shelter Cleveland, OH

- Prepared and served meals with other students monthly as service chairperson of AMSA

2001- 2002 OSU Emergency Department Columbus, OH

- Survivor Advocate for Sexual Assault/Domestic Violence Survivors
- Responsible for emotionally supporting and giving information to victims who arrive at the emergency department

1998- 2000 Ohio State University Medical Center Columbus, OH

- Volunteered in Cardiac Inpatient Care Unit, Ambulatory Surgery, Maternity Ward, Internal Medicine, and Intensive Care

1998-2001 Indianola Middle School Columbus, OH

- Tutored inner-city middle school students weekly in reading, math, science, and English

Professional Societies

2005-present	American College of Emergency Physicians/Emergency Medicine Residents' Association member
2005-present	Society for Academic Emergency Medicine member
2007-present	American Academy of Emergency Medicine member

Licensure and Certification

- Board eligible in Emergency Medicine in June 2009
- State of Tennessee Medical License #44122
- United States DEA registered
- ACLS certified, expiration August 2010
- PALS certified, expiration July 2010
- BLS certified, expiration August 2010
- ATLS certified, expiration August 2011

Interests

- Exercise, golf, basketball, softball, tennis, movies, reading

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: Christine T. Coleman, MD

INSTITUTION: Am Board of Emergency Medicine

REPRESENTATIVE'S NAME: Shannon

PHONE NUMBER: 1-517-332-4800, Ext. 381

INFORMATION VERIFIED: EM Board certified

June 14, 2010 - Dec. 31, 2020

DATE/TIME: 4/6/2011, 1:55pm

VERIFIED BY: Jess Baugher, Medical Staff Services

Aubrey Michael Delk, M.D.
413 Black Mountain Drive
Antioch, TN 37013
(615) 477-1314
michael.delk@vanderbilt.edu

Education:

Vanderbilt University Medical Center
Emergency Medicine Residency Program
To be completed, June 2009

University of Tennessee College of Medicine
Doctor of Medicine
Honors, May 2006

Lipscomb University
Bachelor of Science, Biochemistry and Biology
Mathematics minor
Magna cum laude, May 2002

Honors:

- Alpha Omega Alpha, Tennessee Beta Chapter, 2005
- Billy and Sally Gore Scholarship, 2003-2004
- NIH Medical Student Research Fellowship Award, 2003
- Alpha Chi Honor Society, 1999-2002
- Dean's Honor Scholarship, 1997-2002
- Ned McWherter Scholarship, 1997-2002
- Varsity Baseball Letter, Lipscomb University, 1999

Medical and Employment Experiences:

- Emergency Nurse Technician, Bedford County Medical Center, Shelbyville, TN, 1998-2000
- General Chemistry Lab Assistant, Lipscomb University, Nashville, TN, 1999
- Commercial Landscaping, Goostree's Lawn Service, Joelton, TN, 2000-2002
- Server, Ruby Tuesday Inc., Nashville, TN, 2001
- Forklift Operator, American Freightways, Nashville, TN, 2000-2001

Extracurricular Activities:

- House Staff Advisory Council, Vanderbilt University Graduate Medical Education, 2008-present
- CPR Training Coordinator, University of Tennessee College of Medicine, 2005-2006
- University of Tennessee Community Disaster Response Team, 2003-2006
- Medical Student Representative, Baptist Collegiate Ministry, 2003-2004
- Elementary Student Mentor, Hattie Cotton Elementary, 1998-2000
- Varsity Baseball, Lipscomb University, 1997-1999

Research and Lectures:

- Cell Signaling through the Muscular Dystrophy Protein Complex, NIH Summer Research
  Advisor: Harry W. Jarrett, Ph.D.
- Important Aspects in Radiological Device Injuries, presented with Eric Speckner through the University of Tennessee Community Disaster Response Team Lecture Series

Personal Interests:

- Camping, golfing, assorted outdoor family activities, home improvement

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: Aubrey Michael Deik

INSTITUTION: Am Board of Emergency Medicine

REPRESENTATIVE'S NAME: Shannon

PHONE NUMBER: 1-517-332-4800, Ext. 381

INFORMATION VERIFIED: EM Board Certified

Nov. 19, 2010 through Dec. 31, 2020

DATE/TIME: 4/7/2011, 9:52Am

VERIFIED BY: Jess Baugher, Medical Staff Services

susan.geiger@wright.edu

Susan B. Geiger

937.238.0288

15 Grandon Road Dayton, Ohio 45419

EDUCATION

Wright State University Boonshoft School of Medicine, Dayton, Ohio
- Doctor of Medicine, May 2010

Vanderbilt University, Nashville, Tennessee
- Bachelor of Science in the Interdisciplinary Study of Neuroscience, May 2006
- Graduated cum laude

INTERNSHIP AND RESIDENCY

Wright State University Boonshoft School of Medicine, Dayton Ohio
Resident in the Department of Emergency Medicine, June 2010 through Present
- Training in the practice of Emergency Medicine at seven Dayton-area hospitals, including a Level I trauma center, Level II children's hospital, several urban environments, a suburban private hospital and an Air Force hospital

EXPERIENCE

Wright State University Boonshoft School of Medicine, Dayton, Ohio
Member of Pre-Admissions Committee, 2008 through 2010
- Reviewed applicants' admissions files, conducted interviews with applicants, and prepared written analysis of each applicant's qualifications for review by the Admissions Committee

Wright State University Boonshoft School of Medicine, Dayton, Ohio
Full Member of the Admissions Committee, 2007 through 2008
- Reviewed applicants' admissions files, conducted interviews with applicants, prepared written analysis of each applicant's qualifications for review by the Admissions Committee, and discussed applicants' strengths and ability to further the WSU BSOM mission at bi-weekly Admissions Committee meetings

Vanderbilt University, Center for the Americas, Nashville, Tennessee
Visiting Fellow, DNA and the Americas' Ancient Populations, 2006 through 2008
- Assisted in skeletal analysis and skull reconstruction of Wari remains to analyze patterns of skeletal trauma, Summer 2006
- Excavated contact-era Incan skeletal remains in the Colca Canyon, Peru to aid understanding of the Spanish influence on Incan lifeways, Summer 2007
- Researched clinical medicine articles included in Professor Tiffiny Tung, Ph.D.'s course text for *Life, Death and the Human Body* and provided various other research assistance, Fall 2008

Vanderbilt University, Department of Psychology, Nashville, Tennessee
Primate Research Assistant, 2005 through 2006
- Assisted faculty in the care and training of macaque monkeys in preparation for data collection related to the primate auditory cortex

Boonshoft Schizophrenia Center, Wallace-Kettering Neuroscience Institute, Dayton, OH
Research Assistant, Summer 2004 through Spring 2006
- Assisted a research team led by Dr. Douglas Lehrer by tracing neuroanatomy on MRIs and co-registering MRI and PET images in efforts to assess the potential differences between the neuroanatomy of those with schizophrenia and those without

LEADERSHIP

Wright State University Boonshoft School of Medicine, Dayton, Ohio
Co-Chair for the Cadaver Anatomy Procedure Lab, 2012 to present

- Design and implement curriculum and supporting plans for this year's upcoming CAP Lab, a two day series of seminars and hands-on stations for EMS personnel desiring to learn more about human anatomy and practice basic to advanced EMS procedures

Committee Member for the Cadaver Anatomy Procedure Lab, 2010 through 2011

- Organized resident and faculty volunteers, solicited supplies, and aided with CAP Lab content

Miami Valley School, Alumni Council, Dayton, Ohio
Board Member, Spring 2009 through present

- Fostered alumni awareness and involvement with the current student body in conjunction with the school's by-laws and mission statement
- Assisted with the council's focus on development, community outreach, fundraising events and strengthening the alumni network

Wright State University Boonshoft School of Medicine, Dayton, Ohio
Honor Council Voting Member, 2006 through 2007, *Alternate Member*, 2007 through 2010

- Elected by the class to serve as Class of 2010's Representative to the Honor Council
- Assisted the Honor Council in regulating the academic conduct of students to ensure that the values, ethics, and Honor Code were upheld
- Helped raise Honor Code awareness among the members of the 2010 graduating class

SERVICE

Hospice Of Dayton, Dayton, Ohio
Volunteer, Summer 2009 through 2011

- Moved by the experience hospice provided to my grandmother and family I volunteered with my husband
- Recruited fellow medical students while at WSU BSOM to volunteer time when notified of Hospice of Dayton's need for more medical student volunteers

Phi Rho Sigma, Alpha Upsilon Chapter, Dayton, Ohio
President, 2007 through 2008

- Revitalized involvement in Phi Rho Sigma by expanding service opportunities for members, including: Stuffed Animal Recycling Program benefiting CareHouse, a children's resource center associated with Children's Medical Center of Dayton; the Canned Food Drive, benefiting St. Vincent de Paul's Hotel and Booth House; and, continuing our tradition of service to the Special Olympics organization
- Instituted monthly happy hours and added several other social events to the Fall and Spring WSU BSOM calendars to enable camaraderie among the medical school classes
- Resurrected the traditional initiation ceremony in April 2008, last conducted at WSU BSOM five years prior

Member, 2006 through 2010

- Participated in various service events including the annual Special Olympics swim meet
- Attended monthly meetings and social events

American Medical Women's Association, Wright State University Boonshoft School of Medicine Chapter, Dayton, Ohio
Member, 2007 through 2010

- Served on the planning committee for the 2007 Women in Medicine Gala

PROFESSIONAL ASSOCIATIONS

American Medical Association
Member, 2006 through present

American College Emergency Physicians
Member, 2010 through present

Emergency Medicine Residents' Association
Member, 2010 through present

CERTIFICATIONS

BLS, ACLS, ATLS, PALS

INTERESTS

Dancing, tennis, skiing, sewing, baking, reading and writing poetry

PUBLICATIONS/PRESENTATIONS

White, M.T., Geiger, S.B., & Borges, N.J. (2010, April). Professional Identity Development and Specialty Choice: A Survey of Third and Fourth-Year Medical Students. Poster presented at the Association of American Medical College's Central Group on Educational Affairs Spring meeting, Chicago, Illinois

White, M.T., Borges, N.J. & Geiger, S., Perceptions of Factors Contributing to Professional Identity Development and Specialty Choice: A Survey of Third- and Fourth-Year Medical Students. *Annals of Behavioral Science and Medical Education* 2011, Vol. 17, No. 1, 18-23

REFERENCES

James Brown, M.D.
Chair and Residency Program Director
Wright State University Boonshoft School of Medicine
Department of Emergency Medicine
3525 Southern Blvd, Kettering, Ohio 45429
(937) 395-8839

Norman Schneiderman, M.D.
Emergency Physician, Former Chair of EM Dept
Miami Valley Hospital
One Wyoming Street, Dayton, OH, 45409
(937) 239-9140

Beth Berrettoni, M.D.
Hand & Reconstructive Surgeons, Inc
2350 Miami Valley Drive Ste 310, Centerville, OH, 45459
(937) 435-4263

Tiffiny Tung, Ph.D.
Assistant Professor of Anthropology, Vanderbilt University
VU Station B #356050 2301 Vanderbilt Place Nashville, TN 37235-7703
(615) 322-2553

Edmund Dabney Hadley III, MD
2215 Abbott Martin Rd. Apt 303
Nashville, TN 37215
Edmund.d.hadley@vanderbilt.edu
931-249-7318

Education and Medical Training

Residency 07//2012—current
Emergency Medicine
Vanderbilt University Medical Center
Nashville, TN

Doctor of Medicine 06/2008 – 05/2012
Wake Forest School of Medicine
Winston-Salem, NC

Undergraduate Degree 08/2008—12/2007
Austin Peay State University
Clarksville, TN

Licensure and Certifications

License to Practice Medicine in the State of Tennessee- 2015
Advanced Cardiac Life Support (ACLS)- 2015
Pediatric Advanced Life Support (PALS)- 2015
Basic Life Support (BLS) – 2015
Advanced Trauma Life Support (ATLS)- 2014
Neonatal Resuscitation Program (NRP) - 2012

Professional Memberships

American College of Emergency Physicians (ACEP)
American Academy of Emergency Medicine (AAEM)
Emergency Medicine Residents Association (EMRA)

Honors

Alpha Omega Alpha Honor Society, Wake Forest SOM Chapter, 2012

Gold Humanism Honor Society, Wake Forest SOM, 2012

Additional Accomplishments

Wake Forest Student-Run Free clinic, Winston-Salem, NC
President, Advisory Board, 2012

Wake Forest Student-Run Free clinic, Winston Salem, NC
Director, 2010-2011

Research and Publications

Ongoing Research

Non-invasive Positive Pressure Ventilation for Acute Respiratory Failure in Zambia. University Teaching Hospital, Zambia, Africa

The Effect on Laboratory Data Reporting Times of Implementation of an Electronic Medical Record System, University Teaching Hospital, Zambia, Africa

Publications Peer Reviewed Journal Articles/Abstracts

Chall, A., Hadley, E., Schiller, S.. Oxytocin receptor (OXTR) mRNA expression in human amnion-derived WISH cells.. Journal of the Tennessee Academy of Science. 2009 Jul; 84(3): 41-46.

Poster Presentation

Hadley, E.. (2007, December). The Effect of Estradiol-17[beta], Progesterone and Dibutyrl-cAMP on Expression of Oxytocin Receptor mRNA.. Poster presented at: Tennessee Academy of Science, General Assembly Meeting; Nashville, TN.

Hadley, E.. (2009, October). Physician Preparedness for an Avian Influenza Outbreak in India.. Poster presented at: Wake Forest Medical Student Research Day; Winston-Salem, NC.

Proctor, S., Hadley, E.. (2009, November). Delivering Equal Access to Care. The Wake Forest Student Run Free Clinic.. Poster presented at: Faces of Healthy Future: National Conference to End Health Disparities; Winston-Salem, NC.

3818 West End Ave, #305
Nashville, TN 37205

(407) 222-1181
jill.e.lawton@vanderbilt.edu

Jill Emmons Lawton, M.D. Heavrin

Education

2002-2006 University of Miami Miller School of Medicine Miami, FL
- Doctor of Medicine degree
- Alpha Omega Alpha

1998 –2002 Vanderbilt University Nashville, TN
- Bachelor of Science in Neuroscience
- *Magna cum laude*, Phi Beta Kappa

1994-1998 Winter Park High School Winter Park, FL
- Valedictorian

Work Experience

2006-present Vanderbilt University Medical Center Nashville, TN
- Emergency Medicine residency training

2003 Vanderbilt University
Department of Cognitive Neuropsychology Nashville, TN
- Research Assistant

2001 Dean, Ringers, Morgan and Lawton Orlando, FL
- Transcriptionist

2000 House of Hope Orlando, FL
- Math, science and Spanish tutor

1997-1999 Einstein's Brothers Bagels Winter Park, FL
- Employee, line worker

Achievements

- Alpha Omega Alpha, 2006
- Phi Beta Kappa, Vanderbilt University Chapter, 2002
- Gamma Beta Phi Community Service Honor Society, Vanderbilt University Chapter, 1999-2002
- Dean's List, Vanderbilt University, 1998-2002
- President's List, Vanderbilt University, 1998-2002
- Who's Who of America's High School and College Students
- Valedictorian Winter Park High School, 1998
- Society of Women Engineers Scholarship, 1998

Leadership

2006 University of Miami School of Medicine Student Council Miami, FL

- Event Chair

2006 UMSM Emergency Medicine Interest Group Miami, FL

- Co-coordinator

2005-2006 UMSM Academic Societies Miami, FL

- Academic Chair

2005-2006 American Medical Association, UM Chapter Miami, FL

- Smoking Cessation Education Chair

2004-2006 UMSM Alternative Medicine Club Miami, FL

- Secretary

2003-2006 UMSM Nicaragua Medical Missions Miami, FL

- Resource Planner

Research

2008

- Reducing Radiation Exposure in the Vanderbilt University Adult Emergency Department

Residents in my class are working on a systems improvement research project with the goal of creating protocols to reduce radiation exposure in our emergency department. The project will be completed June, 2009.

2005-present

- MRSA Colonization: A Study of Emergency Medicine Residents

I am currently collecting data that shows the changes in MRSA nasal colonization as residents progress through training. I plan to submit this for publication February, 2009.

2000-2001

- Vanderbilt Neuroscience Department Research Assistant

I took part in testing and analyzing results on studies involving visual discrimination and font recognition that led to the following publication: Gauthier, I., JamesT, W., Curby,K .M. & Tarr,M .J. (2003). The influence of conceptual knowledge in visual discrimination. Cognitive Neuropsychology. 3/4/5/6:507- 523.

Professional Societies

2005-present

- American College of Emergency Physicians/Emergency Medicine Residents' Association Member

2005-present

- Society of Academic Emergency Medicine Member

2007-present

- American Academy of Emergency Medicine Member

Licensure and Certification

- Board eligible in Emergency Medicine
- State of Tennessee Medical License
- United States DEA, registration to be completed 12/08
- ACLS certified, expiration 8/2010
- PALS certified, expiration 7/2010
- BLS certified, expiration 7/2010
- ATLS certified, expiration 8/2011
- Neonatal resuscitation program certified

Selected Volunteer Experience

2008
Vanderbilt Emergency Medicine Residency Community Service
I have helped coordinate our first community service projects as a residency program. We have completed a clean up day at Percy Warner Park, and we are currently collecting gifts for a family in need for the holidays. I look forward to expanding this new aspect of our residency program.

2007
Utila, Honduras
I traveled to Honduras during an elective month and worked in 2 clinics. This was an opportunity for me to learn about healthcare with limited resources.

2004-2006
DOCs Service Clinic
DOCs is a student-run clinic through the University of Miami. I participated in the clinic frequently during my last 2 years of medical school.

2004-2006
Florida Keys Health Fair
Each year, students and doctors from the University of Miami organize and staff health fairs at three different sites in the Keys. I was involved in pediatrics, and I helped teach taking and documenting vital signs.

2004-2006
Nicaragua Medical Missions
During spring break our group traveled to Nicaragua and opened free health clinics at different sites in the city of Managua. I helped obtain monetary donations and supplies in addition to traveling and working in the clinics in 2004.

American Board of
Emergency Medicine

American Board of Emergency Medicine

Established for the Certification of Emergency Physicians Hereby Declares that

JILL LAWTON HEAVRIN, M.D.

Has Successfully Fulfilled the Certification Requirements and is Declared a Diplomate of the American Board of Emergency Medicine

November 19, 2010 – December 31, 2020

President Mark T. Steele, M.D.

Secretary John Moorhead M.D.

Certification Number 48566

David Ludwell Lanier, MD
140 Edgewater Lane
Wilmington, NC 28403
910-352-6730

Curriculum Vitae

Current employment:

Attending Physician, Lake Charles Memorial Hospital Emergency Department.

1 34,000-39,000 annual visit Emergency Department, Level 2 Trauma Center in Lake Charles, Louisiana.
2 Single Physician coverage for 12 hour shifts, with NP coverage.
3 July 1998-present.

Doctors Without Borders Experience:

13 months as Refugee Camp Physician for Maela Refugee Camp on the Burmese border of Thailand (January 2003-February 2004).

1 Responsible for supervision of two hospitals serving a population of 40,000 Burmese refugees from an ongoing civil war.
2 Single expatriate physician, 5 expatriate team members: refugee volunteers serve as medics, nurses, water/sanitation workers, etc.

Training/Certification:

1 Residency-trained in Emergency Medicine, The Johns Hopkins Hospitals Department of Emergency Medicine Residency Program, Baltimore, Maryland, July 1995 to June 1998.
2 Board Certified in Emergency Medicine, American Board of Emergency Medicine, through December 2009.

Education:

1 Doctor of Medicine, The University of North Carolina at Chapel Hill School of Medicine, August 1991 to May 1995.
2 Bachelor of Science in Biology, The University of North Carolina at Chapel Hill, August 1988 to December 1990.

Personal:

1 35 years old
2 Born in Newport News, Virginia, December 19, 1969
3 Single

Languages:

Native English, and fair conversational Spanish.

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: David Lanier, MD

INSTITUTION: American Board of Emergency Medicine

REPRESENTATIVE'S NAME: Linda

PHONE NUMBER: 517-332-4800 ext. 381

INFORMATION VERIFIED He has a new certification number which is 27595. He is certified 10-20-2009 – 12-31-2019.

DATE/TIME: December 16, 2009 9:30 AM

VERIFIED BY: Tammy Carter, Medical Staff Services Assistant

Markus T. Leong, M.D.

37 Salmon Street
San Francisco, CA 94133
markusleong@yahoo.com
(415) 238-9175

PROFESSIONAL EXPERIENCE

2003-present **Kaiser Permanente Medical Center** South San Francisco, CA
Staff Emergency Physician
- Full time clinical practice. TPMG partner status in 2006.
- ED committee: Patient Safety and Satisfaction
- Hospital committee: Physician Well-Being

2011-present **Kaiser Permanente Medical Center** Modesto, CA
Staff Emergency Physician
- ED coverage for meeting days

TRAINING & EDUCATION

2000-2003 **Beth Israel Medical Center** New York, NY
Manhattan Campus of the Albert Einstein College of Medicine
Resident in Emergency Medicine
- 2003 Bernard B. Berger MD senior resident award for clinical excellence

1996-2000 **George Washington University School of Medicine** Washington, DC
Degree: M.D.
- Student representative on the Honor Code Council

1994-1996 Pre-medical coursework at San Francisco State and Georgetown University

1992-1994 **California Institute of Integral Studies** San Francisco, CA
Degree: Ph.D. in Chinese Philosophy
- Thesis on the Ming dynasty philosopher Hanshan Deqing (1546-1623).

1988-1992 **University of California, Berkeley** Berkeley, CA
Degree: B.A. in East Asian Languages and Cultures
- Honors thesis on the the Chinese Dunhuang record of Bsam-yas.

CERTIFICATIONS

American Board of Emergency Medicine (ABEM), diplomat, 2004
National Board of Medical Examiners (NBME), diplomat, 2002
ACLS, PALS, ATLS, Sexual Assault Forensic Examiner (SAFE)

LICENSURE

California Medical License, 2002
Tennessee Medical License, 2012

PUBLICATIONS Leong MT, Gebrial J, Sturmann K, Hsu CK. "The effect of vinegar on colorimetric end-tidal carbon dioxide determination after esophageal intubation." *Journal of Emergency Medicine*. January 2005; 28(1):5-11.

VOLUNTEER ACTIVITIES

2008 *Volunteer doctor*, Delek Hospital, Dharamsala Tibetan Settlement, India

2003 *Volunteer doctor*, Rabgyeling Hospital, Hunsur Tibetan Settlement, India

2003-present "Friends of..."
Volunteer
- Participate in a community theatre group for local children's centers

2000-2001 ACEP Violence Prevention Committee
Committee Member
- Developed ACEP policies on the issues of youth violence, adolescent suicide, and firearm safety.

2000-2003 Regional Medical Advisory Council (REMAC) of New York City
Oral Board Examiner for Paramedics

1997-1998 Asian Pacific American Medical Student Association
Vice-President, George Washington University Chapter
- Organized activities, community health fairs, and guest speakers.

CONFERENCE PRESENTATIONS

"Serpiginous Rash: Cutaneous Larva Migrans."
- Photography Exhibit and Visual Diagnosis Contest
- Society of Academic Emergency Medicine, National Meeting, Atlanta, 2001.

"The Legacy of Yick Gai-Sing (1848-1909)."
- Department of Asian American Studies Conference
- University of Hawaii, Honolulu, 1995.

"Virtue Ethics: a Comparative Analysis of Socratic and Jodo-Shinshu Philosophy."
- International Jodo-Shinshu Studies Conference
- Department of Philosophy, Kyoto University, Japan, 1993.

MEMBERSHIP San Mateo County Medical Association

PERSONAL
Spouse: Nancy Lin
Languages: Mandarin and Cantonese Chinese
Sports: hiking, surfing, swimming

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: Markus Leong, MD

INSTITUTION: American Board of Emergency Medicine

REPRESENTATIVE'S NAME: Christine T.

PHONE NUMBER: 517.332.4800 x 381

INFORMATION VERIFIED: Christine T. verified that the dates of board certification for Dr. Leong are 1/1/2015 – 12/31/2024.

DATE/TIME: 12/19/2014 08:50 AM CST

VERIFIED BY: Kelly Anderson, Medical Staff Services

Geoffrey D. Lifferth, M.D.

9410 Dove Field Court
Brentwood, TN 37027
(615831-3085
glifferth@comcast.net

Certification and Licensure

2003	ABEM Board Certification
2002	Tennessee State Medical License
2000	Massachusetts State Medical License
1997, 2002	ACLS, ATLS, PALS

Education

1997 – 2002	Harvard Emergency Medicine Residency -Chosen 1 of 2 Outstanding EM Residents By Harvard Medical School Class of 2001
1993 – 1997	University of Tennessee, Memphis, School of Medicine
1987 – 1993	Brigham Young University -Graduated with University Honors -BS History, Minor Emphasis Zoology and Japanese

Work Experience

2003—Present	Attending Physician, Summit Medical Center
2002 – 2003	Attending Emergency Physician and Associate Medical Director Beth Israel Deaconess – Needham Hospital
1997 – 2002	Resident Physician Massachusetts General Hospital Brigham and Woman's Hospital Boston Children's Hospital

Academic Appointments

2002 – 2003	Instructor in Medicine, Harvard Medical School

Academic Contributions:

Teaching

1997 – 2002	Resident Conferences -Lectures on Psychiatric Emergencies, Obstetric Emergencies, Dealing with Difficult Patients
1998 – 1999	EMS Continuing Medical Education Courses -Lectures on Trauma, Obstetric Emergencies, Shock
1999 – 2002	Clinical Supervision, Harvard Medical Students and Junior Residents

Publications

1. Li, Y., Lacerda, A., Warman, M.L., Deier, D.R., Yoshioka, H., **Lifferth, G.D.**, Teuscher, C., Woodward, S.R., Taylor, B.A., Seegmiller, R.E., Olsen, B.R. "A Fibrillar Collagen Gene, Col11A1, Is Essential for Skeletal Morphogenesis." *Cell*, Vol. 80, 423-30, Feb. 10, 1995.

2. Editor/Author. "Endocarditis." Micromedex, 1998.

Abstracts

1. **Lifferth, G.,** Lee, L., Moore, R. "Geriatric Patients With Syncope of Unknown Etiology in the Emergency Department." - [abstract] New England Society of Academic Emergency Medicine Annual Meeting, Worcester, MA, 2001.

2. Raemer, D., Shapiro, N., **Lifferth, G.**, Blum, R., Edlow, J. "Testing Probes, a New Method of Measuring Teamwork Attributed in Simulated Scenarios." - [abstract] International Meeting on Medical Simulation, Scottsdale, 2001.

3. Jackson, A.L., Keech, D.S., **Lifferth, G.D.**, Wong, F.S., Robbins, K.T. "Predictive Indicators Among Cancer Patients Who Complete a Cancer Clinical Trial." - [abstract] National Academy of Otolaryngology Annual Meeting, 1996.

Personal

Born May 10, 1969 in Madison, Tennessee; 3rd of 10 children. Married 1992 to Kathleen Tait. Four children, Jon (10) Will (8) and Julia (5) and Henry (1). Personal interests include Backpacking, Woodworking, Running, spending time with family. Fluent in conversational Japanese.

RE: Board Certification in Emergency Medicine for Geoffrey Lifferth, M.D

Talked with the American Board of Emergency Medicine on December 5, 2013 at 2:30 pm by telephone. They verified that Dr. Lifferth had met all his maintenance requirements and his certification will renew on January 1, 2014 for another ten (10) years.

Claire Woodruff

Curriculum Vitae

William Edward Lummus, M.D.

Personal Data

Home Address:	3477 Golf Club Lane Nashville, TN 37215
Home Telephone:	(615) 385-3198
Office Address:	Vanderbilt University Medical Center Department of Emergency Medicine 1313 21st Ave., S. 703 Oxford House Nashville, TN 37232-4700
Office Telephone:	(615) 936-1160
Date of Birth:	September 26, 1969
Place of Birth:	Huntsville, AL
Social Security Number:	416-02-3569

Professional Experience

Resident Physician, Vanderbilt University Medical Center, Department of Emergency Medicine, Nashville, Tennessee, July 1994 to present

Staff Physician, Emergency Physicians of Lawrence County, Columbia Crockett Hospital, Lawrenceburg, Tennessee, August 1996 to present

Education

Undergraduate College

Birmingham-Southern College, Birmingham, Alabama 1987-1990

Honors and Awards:

- Phi Eta Sigma academic honor society
- Alpha Lambda Delta academic honor society
- President's Student Service Organization
- Student Alumni Association
- Presidential Honors Scholarship

No degree secondary to early enrollment into medical school

Medical School

University of Alabama School of Medicine — 1990 to 1994
Birmingham, Alabama
Honors and Awards:
Clarence Long Scholarship
Degree:
Doctor of Medicine

Lectures and Presentations

"Neuro-ophthalmology for the Emergency Physician", presented 6/97 at Vanderbilt University

"Cervical Spine Injuries", presented 8/97 at Vanderbilt University

"Advances in Ischemic Stroke", to be presented 10/97 at Vanderbilt University

Original Research

Ovarian Torsion, clinical characteristics and presentation, to be submitted

Review Articles

Neuro-ophthalmology for the Emergency Physician, to be submitted

Memberships

American College of Emergency Physicians	1993 to present

Certifications

Basic Cardiopulmonary Resuscitation	1990 to present
Advanced Cardiac Life Support	1994 to present
Pediatric Advanced Life Support	1994 to present
Advanced Trauma Life Support	1995 to present

Interests and Activities

Golf, Tennis, Computers

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: William Lummus, MD

INSTITUTION: American Board of Emergency Medicine

REPRESENTATIVE'S NAME: Linda

PHONE NUMBER: 517-332-4800 ext. 381

INFORMATION VERIFIED He has a new certification number which is 26672. He is certified 10-20-2009 – 12-31-2019.

DATE/TIME: December 16, 2009 9:30 AM

VERIFIED BY: Tammy Carter, Medical Staff Services Assistant

Marc A. Mickiewicz, M.D.

Office Address:	Vanderbilt University Medical Center Department of Emergency Medicine 703 Oxford House 1313 21st Avenue South Nashville, Tennessee 37232-4700
Office Phone:	615-936-1324
Office Fax:	615-936-1316
E-Mail:	marc.a.mickiewicz@vanderbilt.edu
Office Address:	VA Tennessee Valley Healthcare System Medical Service, G-205L 1310 24th Avenue South Nashville, Tennessee 37212
Office Phone:	615-873-8506
Office Fax:	615-873-7743
E-Mail:	marc.mickiewicz@va.gov
Cellular:	615-438-7540

Personal

Date of Birth	July 17, 1974
Place of Birth	Parkersburg, West Virginia
Citizenship:	United States of America
Home Address:	8253 Dalewood Court Brentwood, TN 37027
Home Phone:	615-373-9326
Marital Status:	Marcy Yackish Mickiewicz, MSN, ANP-BC, Married: 8/8/2003
Children:	Madelyn Mickiewicz, April 15, 2005 Megan Mickiewicz, November 23,2007

Education

University of Illinois, Urbana, Illinois BS, cum laude; Biology, Honors Option	August 1991 - May 1995
University of Illinois at Chicago College of Medicine, Peoria, IL MD, Honors	August 1995 - May 1999
University of Michigan Health System, Emergency Medicine Residency Ann Arbor, Michigan	July 1999 - June 2002
University of Michigan Health System, Emergency Medicine Residency Ann Arbor, Michigan Chief Resident	July 2002 - June 2003

Licensure and Certifications

State of Tennessee, Medical Doctor	License Number 37402	March 2003 - Present
DEA Certification		Expires January 2014
Diplomat, American Board of Emergency Medicine		November 11, 2004
Diplomat, National Board of Medical Examiners		August 29, 2001
Basic Life Support / Advanced Cardiac Life Support		Expires October 2013
Pediatric Advanced Life Support:		Expires October 2013
Advanced Trauma Life Support:		Expires February 2015

Academic Appointments

Instructor, Department of Emergency Medicine Vanderbilt University Medical Center	July 1, 2003 - June 30, 2004
Assistant Professor, Department of Emergency Medicine Vanderbilt University Medical Center	July 1, 2004 - Present

Hospital Appointments

Vanderbilt University Medical Center	July 1, 2003 - Present
Vanderbilt Children's Hospital	July 1, 2003 - Present
VA Tennessee Valley Healthcare System, Nashville Campus	July 1, 2008 - Present

Professional Organizations

Fellow, American Academy of Emergency of Medicine	2010
Society of Academic Emergency Medicine Chair, Investment Subcommittee 2007-2009	2007 – 2009

Professional Activities

Medical Director, Emergency Department VA Tennessee Valley Healthcare System Nashville Campus	July 2008 - Present
Section Chief, Emergency Medicine, Medical Service VA Tennessee Valley Healthcare System	July 2008 - Present
Stroke Team Director, VA Tennessee Valley Healthcare System	December 2011 - Present

CPR Committee, VA Tennessee Valley Healthcare System — July 1, 2008 - Present

Hospital Disaster Committee
VA Tennessee Valley Healthcare System — July 1, 2008 - Present

Leader, Patient Flow Coordination Collaborative
VA Tennessee Valley Healthcare System — January 2008 - January 2009

Medical Director, Emergency Department Chest Pain Center
Vanderbilt University Medical Center — July 2004 - July 2008

Teaching activities

Education Director - Nashville VA
Vanderbilt University Medical Center Emergency Medicine Residency Program — **2008 - Present**

Site Director, Vanderbilt University School of Medicine Emergency Department Clerkship (EM 5950) — **2010 - Present**

Substantially improved the educational experience of residents and medical students working in the Nashville VA Emergency Department. Board certified Emergency Medicine physicians now supervise and teach residents and medical students. Introduced airway management, use of bedside ultrasound, and other advanced acute care strategies to what were formerly just "triage" shifts.

Co-creator, Vanderbilt University Education and Evaluation Faculty Forum — **2006 - Present**

This is an ongoing resident evaluation forum that meets at least twice a year to provide a consensus evaluation and obtain candid feedback for all emergency medicine residents. It has greatly improved the quality of resident feedback since its inception.

Didactic and bedside teaching — **2003-Present**

Teach constantly at the bedside in the emergency departments of Vanderbilt University Medical Center and the Nashville VA (10-15 shifts per month since 2003). Frequently give didactic lectures to medical students and residents. Please refer to attached Teaching Portfolio for more information.

Continuing Medical Education Lectures

Vanderbilt Emergency Medicine, State of the Art Update in Emergency and Acute Care 2006
Lecturer – "Pulmonary embolism, deep venous thrombosis and bleeding from anticoagulation"

Society of Emergency Medicine Physician Assistants, 2nd Annual Emergency Medicine Conference 2006
Lectures – "Becoming proficient with recognition and management of sodium and potassium disorders"
"Low risk acute coronary syndrome, how much evaluation is enough?"

Publications

Journals

Huang RL, Donelli A, Byrd J, Mickiewicz MA, Slovis C, Roumie C, Elasy TA, Dittus RS, Speroff T, Disalvo T, Zhao D. Using quality improvement methods to improve door-to-balloon time at an academic medical center. J Invasive Cardiol. 2008 Feb;20(2):46-52.

Younger JG, Shankar-Sinha S, Mickiewicz M, Brinkman AS, Valencia GA, Sarma JV, Younkin EM, Standiford TJ, Zetoune FS, Ward PA. Murine complement interactions with Pseudomonas aeruginosa and their consequences during pneumonia. Am J Respir Cell Mol Biol. 2003 Oct;29(4):432-8.

Book chapters and invited review articles

Dobbs M, Buckingham C, Mickiewicz M. Soft tissue conditions of the neck. The Atlas of Emergency Radiology. McGraw-Hill, 2012 (in press).

Schneider C, Mickiewicz M. Low-to-intermediate risk chest pain. Manual of Intensive Care Medicine, 5th Ed. Rippe Lifestyle, 2008.

Seamens C, Mickiewicz M. Esophageal Emergencies. The Clinical Practice of Emergency Medicine. Lippincott, Williams and Wilkens. 2004

Mickiewicz M, Dronen SC, Younger JG. Central venous catheterization and central venous pressure monitoring. *Clinical Procedures in Emergency Medicine, 4th Ed.* W.B. Saunders, 2003.

Mickiewicz M, Gomez HF. Hydrocarbon toxicity: General review and management guidelines. Air Medical Journal 2001 20:8-11.

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: Marc Mickiewicz, MD

INSTITUTION: American Board of Emergency Medicine

REPRESENTATIVE'S NAME: Christine T.

PHONE NUMBER: 517.332.4800 x 381

INFORMATION VERIFIED: Christine T. verified that the dates of board certification for Dr. Mickiewicz are 1/1/2015 – 12/31/2024.

DATE/TIME: 12-19-2014 08:50 AM CST

VERIFIED BY: Kelly Anderson, Medical Staff Services

James Parnell, M.D.

jamesandrewparnell@gmail.com
Cell: 615.887.5890
Address: 4726 Abbay Drive, Nashville, TN 37211

:ucation

University of Tennessee College of Medicine — Memphis, TN
Doctor of Medicine, High Honors, May 2010
Certificate Program in Health Systems and Leadership, May 2010

Lipscomb University — Nashville, TN
Valedictorian, Bachelor of Science with major in Biology, minor in Chemistry, May 2006

Licensing Exams

USMLE Step One: 247/99
USMLE Step Two: Clinical Knowledge: 255/99, Clinical Skills: Pass
USMLE Step Three: 227/84

Certifications and Licenses

Advanced Trauma Life Support, 2011 - present
Neonatal Resuscitation Program Provider, 2010 - present
Advanced Cardiac Life Support, 2009 - present
Basic Life Support for Healthcare Provider, 2008 - present
Tennessee Medical License, April 2012 - present

Awards and Honors

Gold Humanism Honor Society, Inducted April 2009
Gooch Scholarship, University of Tennessee College of Medicine, 2009
Tennessee Medical Education Fund Scholarship Winner, August 2007, August 2008
Goodpasture Bible Award, Lipscomb University, May 2006
Bachelor of Ugliness (Peer elected award as male equivalent of "Miss Lipscomb"), Lipscomb University, 2006
Alpha Chi National Collegiate Honor Society
Lipscomb University Presidential Merit Scholar

:tivities and Leadership

Resident Coordinator for Radiation Emergency Disaster Drill, Vanderbilt University Medical Center, 2011-2012
Otter Creek Church of Christ Member, Nursery Worker, 2010-present
Emergency Medicine Interest Group, UT College of Medicine, Member 2007-2009, President 2009-2010
American Academy of Emergency Medicine Site Coordinator for UT College of Medicine, 2009-1010
Clinica Esperanza (A weekly free clinic run by UTCOM students for uninsured patients), Clinic Leader, 2009
American College of Emergency Physicians/Emergency Medicine Residents Association Member, 2009
White Station Church of Christ Member, Young Adult Small Group Leader, Youth Bible Class Teacher 2007-2009
Peer Mentor Group Leader for UT College of Medicine Class of 2011, 2007-2008
Health Policy Education Group, UT College of Medicine, 2006-2009
American Medical Association/Tennessee Medical Association Member, 2006-2009
Alpha Phi Chi Service Club of Lipscomb University, 2002-2006, President 2005-2006, Chaplain 2004-2005
Lipscomb University Integrity and Honor Council, 2005-2006
Lipscomb University Study Abroad Program in Vienna, Austria, Fall 2003

Experience and Employment

Emergency Medicine Resident Physician, PGY-3 — Nashville, TN
Vanderbilt University Medical Center, July 2010 - present

Research Assistant — Nashville, TN
Vanderbilt University Medical Center, Pulmonary and Critical Care, June 2007–August 2007

Lipscomb University Residence Life — Nashville, TN
Head Resident Assistant, Lipscomb University, May 2005-May 2006
Resident Assistant, Lipscomb University, May 2003-May 2005

Abstract Presentations

Giddings, O.K., Collard, H., Davidson, M., Loyd, J.E., Mallow, B., Mason, W., **Parnell, J.**, Lancaster, L. *Treatment with continuous positive airway pressure improves survival in patients with idiopathic pulmonary fibrosis and obstructive sleep apnea.* Am. J. Respir. Crit. Care Med. 185:A3637, 2012.

Parnell, James A. *Obstructive Sleep Apnea Is Common in IPF Patients.* University of Tennessee Alpha Omega Alpha - St. Jude Research Lectureship and Student Research Presentation, Memphis, Tennessee, November 2008.

Lancaster L., Mason W., Parnell J., Rice T., Loyd J., Milstone A., Collard H., Malow B. *Obstructive Sleep Apnea Is Common in IPF Patients*. American Thoracic Society International Conference; Ontario, Canada. May 2008.

Publications

L.H. Lancaster, W.R. Mason, J.A. Parnell, T.W. Rice, J.E. Loyd, A.P. Milstone, H.R. Collard, B.A. Malow, Obstructive Sleep Apnea Is Common in IPF Patients. Chest 2009; 136; 772-778.

Lectures and Public Speaking

Parnell, James A. Donaldson Christian Academy Career Day. Nashville, TN. November 13, 2012.

Parnell, James A. "Toxicology Lecture: Lipids". Emergency Medicine Tuesday Conference Lecture. Vanderbilt University Medical Center. Nashville, TN. August 14, 2012.

Parnell, James A. "Keynote Address". Lipscomb University Presidential Scholar Weekend. Country Music Hall of Fame. Nashville, TN. February 10, 2012.

Parnell, James A. "Chest Trauma". Vanderbilt Lifeflight EMS Night Out. Manchester, TN. November 15, 2011.

Parnell, James A. "Radiation Emergency Basics". Emergency Medicine Tuesday Conference Lecture. Vanderbilt University Medical Center. Nashville, TN. November 8, 2011.

Parnell, James A. "Elbows". Emergency Medicine Tuesday Conference Lecture. Vanderbilt University Medical Center. Nashville, TN. December 14, 2010.

Parnell, James A. "PPD and Who to Treat". Preventive Medicine Seminar . University of Tennessee College of Medicine. Memphis, TN. April 21, 2010.

Parnell, James A. "Painless Vision Loss in the ER". Emergency Medicine Conference. University of Tennessee College of Medicine. Chattanooga, TN. May 29, 2009.

Parnell, James A. "Dysfunctional Uterine Bleeding". OBGYN Lecture Series . University of Tennessee College of Medicine. Memphis, TN. January 21, 2009

Parnell, James A. "Asthma: Are Your Lungs Bloated?". Family Medicine Lecture Series . University of Tennessee College of Medicine. Memphis, TN. October 12, 2008.

Personal Interests

My hobbies include spending time with wife and son, playing tennis, grilling, and watching University of Tennessee football and basketball. I also enjoy traveling and participating in humanitarian mission efforts which have taken me to Mexico, South Africa, Japan, and Europe.

Curriculum Vitae

John R. Pinkston, M.D.

Personal Data

Address:	1114 Lochland Drive Gallatin, TN 37066 (615) 264-2717
Born:	September 18, 1963
Social Security #:	415-33-5695
Family:	Married for 7 years to Carrie Nourse Pinkston, one child, Jack, age two

Certifications

Board eligible in Emergency Medicine

Board ~~eligible~~ certified in Internal Medicine

Tennessee Medical License

Advanced Cardiac Life Support provider and instructor

Advanced Trauma Life Support provider

Pediatric Advanced Life Support Provider

Graduate Medical Education

Emergency Medicine Resident
Vanderbilt University Medical Center
July 1993 to June 1997

Internal Medicine Intern and Resident
Vanderbilt University Medical Center
July 1991 to June 1993

Education

Undergraduate Medical
University of Tennessee College of Medicine, Memphis, TN
Doctor of Medicine, 1991
GPA 3.75, Rank 18 of 145

Undergraduate College
Vanderbilt University
Bachelor of Science, 1986
GPA 3.49, cum laude

Honors

Chief Resident, Department of Emergency Medicine
July 1996 to June 1997

Graduated with High Honors from University of Tennessee College of Medicine

Frances Washburn Scholarship, Senior year of Medical School

Graduated cum laude from Vanderbilt University

Research

Case Report: Multi-Organ System Failure Due to Valprate Toxicity, published in The American Journal of Emergency Medicine, July 1997

Incidence of alcohol related visits to the Emergency Department in undergraduate college students, submitted

Work Experience

Sumner Regional Medical Center, Gallatin, TN
Attending Emergency Physician
Part-time from December 1994 to June 1997,
Full-time since July 1997

Physician Medical Director
Sumner County Ambulance Service
June 1997 to present

Vanderbilt University Medical Center
Attending Emergency Physician
Part time from October 1997 to Present

VERIFICATION VIA TELEPHONE CALL

PRACTITIONER: John Ray Pinkston, MD

INSTITUTION: American Board of Emergency Medicine

REPRESENTATIVE'S NAME: Debbie

PHONE NUMBER: 517-332-4800 ext. 381

INFORMATION VERIFIED: Recertification 12/14/2007 -

12-31-2017.

DATE/TIME: 12/31/2008 9:00AM

VERIFIED BY: Tammy Carter Medical Staff Assistant

Kimberly R. Plourde, MD

1064 Island Brook Drive; Hendersonville, Tennessee 37075
Phone: 615 300 4815 · Email: Kimberly.Plourde@vanderbilt.edu

Training and Education

07/04 – 06/07	**Vanderbilt University** Emergency Medicine Residency Nashville, Tennessee
08/00 – 06/04	**University of Texas Health Science Center at Houston** Degree: Doctor of Medicine Houston, Texas
08/96 – 12/99	**Mississippi State University** Degree: Bachelor of Science, *summa cum laude* Major: Microbiology Starkville, Mississippi

Professional Experience

07/08-present	Vanderbilt University Assistant Professor of Emergency Medicine Department of Emergency Medicine Nashville, Tennessee
07/07 – 06/08	Vanderbilt University Medical Center Clinical Instructor in Emergency Medicine Chief Resident, Department of Emergency Medicine Nashville, Tennessee

Licensure and Certifications

Licensed physician in Tennessee
Board Certified: American Board of Emergency Medicine
Advanced Trauma Life Support Instructor
Advanced Trauma Life Support Provider
Advanced Cardiac Life Support Provider
Basic Life Support Provider
Pediatric Advanced Life Support Provider

Professional Activities

Instructional video for Metro-Nashville EMS: Implantable Cardioverter-Defibrillators
EMS Night Out Lecture Series: Environmental Emergencies, August 2006

Awards and Honors

Elected to serve as Chief Resident: July 2007-June 2008
Ian D. Jones, M.D., Chief Resident's Award: June 2006
Alpha Omega Alpha Honor Medical Society
Mississippi State University President's Scholar

Professional Memberships

Fellow American Academy of Emergency Medicine

Personal

Enjoy spending time with my husband, son, and two dogs, reading, baking, and watching Mississippi State sports.

References

Available upon request

American Board of Emergency Medicine

Established for the Certification of Emergency Physicians Hereby Declares that

KIMBERLY RENEE PLOURDE, M.D.

Has Successfully Fulfilled the Certification Requirements and is Declared a Diplomate of the American Board of Emergency Medicine

November 13, 2008 – December 31, 2018

President Harold A Thomas MD

Secretary Mark T. Steele, M.D.

Certification Number 40964

TRAVIS L. STORK, MD

MEDICAL TRAINING & EDUCATION

July, 2003 - July, 2006 — Nashville, TN
Vanderbilt University Medical Center Dept. of Emergency Medicine
- Emergency Medicine Resident Physician

August, 1999 – May, 2003 — Charlottesville, VA
University of Virginia School of Medicine
- Medical Degree
- Alpha Omega Alpha Honor Society

August, 1990 – May, 1994 — Durham, NC
Duke University
- BA in Mathematics and Economics
- Phi Beta Kappa
- Magna Cum Laude

PROFESSIONAL EXPERIENCE

July, 2008 – present — Los Angeles, CA
The Doctors, CBS Television Distribution
- Host of the Emmy award-winning medical information talk show

January, 2013 – present — Sunrise, FL
MDLIVE (a leading telehealth provider)
- Chairman of Medical Advisory Board, Credentialed Provider

Dec, 2008 – Dec, 2011 — Nashville, TN
Vanderbilt University Medical Center
- Clinical Instructor of Emergency Medicine

August, 2006 – Nov, 2008 — Denver/Frisco, CO
St. Anthony Summit Medical Center, St. Anthony North Hospital, St. Anthony Central Hospital
- Emergency Medicine Attending Physician

July, 1994 – July, 1999 — Washington, DC
Watson Wyatt Worldwide
- Account Management Consultant and Actuarial Consultant for international consulting firm (after college and prior to attending medical school).

OTHER

- Diplomate, American Board of Emergency Medicine
- Medical Advisory Board, *Men's Health* magazine
- New York Times Bestselling Author with book publications including *The Doctor is In, The Doctor's Diet Cookbook, The Doctor's Diet, The Lean Belly Prescription*
- Wu, J., **Stork, T.**, Perron, A., and Brady, W. The Athlete's Electrocardiogram. *The American Journal of Emergency Medicine.* 24:77-86, 2006

American Board of Emergency Medicine

American Board of Emergency Medicine

Established for the Certification of Emergency Physicians Hereby Declares that

TRAVIS LANE STORK, M.D.

Has Successfully Fulfilled the Certification Requirements and is Declared a Diplomate of the American Board of Emergency Medicine

December 6, 2007 – December 31, 2017

President Rita K Cydulka MD

Secretary Debra Perina, MD

Certification Number 38495

Michelle Marie Walther, MD

3000 Hillsboro Pike, #47
Nashville TN, 37215
Cell: 615-428-2356
Email: mmwalther@gmail.com

Post-Graduate Medical Education

Vanderbilt University School of Medicine — July 2009-June 2010
Emergency Medicine Residency
Nashville, TN

- Vanderbilt University Hospital
- Monroe Carrell Jr. Children's Hospital at Vanderbilt
- Vetran's Administration Hospital, Nashville, TN

Vanderbilt University School of Medicine — June 2012-June 2013
Department of Emergency Medicine
Chief Resident

Education

Vanderbilt University School of Medicine — July 2005-May 2009
Nashville, TN
Doctor of Medicine

University of Pennsylvania — August 2001-May 2005
Philadelphia, PA
Bachelor of Arts in Biological Basis of Behavior, Cum Laude
Minor in Chemistry

Fargo South High School — September 1997-May 2001
Fargo, ND

Licensure and Certificates

USMLE Step 1,2 &,3	Completed September 2010
Medical Licensing Board – TN Physician Licensure	MD0000047873
DEA Registration	FW2934354
Advanced Cardiac Life Support (ACLS)	July 2008 - Present
Pediatric Advanced Life Support (PALS)	July 2009 - Present
Advanced Trauma Life Support (ATLS)	July 2010 - Present

Residency Activities

Specialty Speed Dating, Vanderbilt School of Medicine	January 2011
Residency Applicant Interviewer	2010, 2011 Interview Seasons
Residency Applicant Hosting Coordinator	2009, 2010 Interview Seasons
Emergency Department IM Softball Team	Spring 2010

Emergency Medicine Work Experience

Vanderbilt University Hospital Emergency Department — July 2009-Present
Nashville, TN
Level 1 Trauma Center, 60,000 visits/year, 55 beds

Monroe Carroll Jr. Children's Hospital at Vanderbilt Emergency Department — July 2009-Present
Nashville, TN
Level 1 Pediatric Trauma Center, 60,000 visits/year, 33 beds

Veteran's Administration Hospital Emergency Department — July 2010-Present
Nashville, TN
30,000 visits/year, 20 beds

Other Work Experience

The Princeton Review, Organic Chemistry MCAT Tutor — July 2006-July 2007
Chiron Corporation, Summer Intern — 2003-2005, Summers only
Pharmacokinetics Animal Lab
Chiron Corporation, Summer Intern — 2002, Summer
X-Ray Crystalography

Publications and Research

Walther, Michelle, N. Starke, BG Johnson RN, CB Creech MD MPH, "Frequency of Community-Associated Methicillin-Resistant *Staphylococcus Aureus* (CA-MRSA) Nasal Colonization in Adolescents," Poster Presentation at Pediatric Infectious Disease Society meeting at St. Jude. January 2007.

Walther MD, Michelle, NS McCoin MD. "Luxatio Erecta of the Hip." Case report submitted to JEM August 2011

MRSA Colonization: A Study of Emergency Medicine Residents — 2009-Present
Children's Hospital of Philadelphia, Research Assistant — 2001-2005
Violence Intervention Project

Residency Presentations and Lectures

The Seven Deadly Causes of Chest Pain — June 2011
Trinity School of Medicine, Seminars in EM
Anaphylaxis — June 2011
Trinity School of Medicine, Seminars in EM
Hyperkalemia — June 2011
Trinity School of Medicine, Seminars in EM
Review of Prehospital Burn Diagnosis and Management — August 2010
EMS Night Out
Dental Emergencies — July 2010
EM Tuesday Conference
The Foot – Injuries and Infections — June 2010
EM Tuesday Conference

Professional Organizations

American Academy of Emergency Medicine (AAEM)	2008-Present
American College of Emergency Physicians (ACEP)	2008-Present

Honors and Awards

Vanderbilt University School of Medicine, McMannis Scholarship recipient, Academic Year 2008-2009
Microbes and Defense Academic Society, October 2007 – May 2009
Neurology Student of the Clerkship, May 2008
Alpha Phi Foundation Scholarship recipient, Academic years 2007 and 2008
University of Pennsylvania, Dean's List, Spring 2004
University of Pennsylvania, National Society of Collegiate Scholars, 2002-2006

Additional Information

Hometown: Fargo, ND, among many others
Hobbies include: hiking, biking, jogging, playing with my dog, group fitness classes, baking, and reading

American Board of
Emergency Medicine

American Board of Emergency Medicine

Established for the Certification of Emergency Physicians Hereby
Declares that

MICHELLE MARIE WALTHER, M.D.

Has Successfully Fulfilled the Certification Requirements and is
Declared a Diplomate of the American Board of Emergency Medicine

June 13, 2013 — December 31, 2023

President [illegible]

Secretary [illegible]

Certification Number 53813

Tab 17

Attachment C
Contribution to the Orderly Development of Health Care – 5

Continuous Quality Improvement Plan

SUMNER Regional Medical Center
HIGHPOINT HEALTH SYSTEM

Effective:	*01/1991*
Approved:	*03/2015*
Last Revised:	*03/2015*
Expiration:	*03/2016*
Policy Area:	*Hospital-wide Hospital Plans*
Applicability:	*Sumner Regional Medical Center*

Continuous Quality Plan, E-500

SCOPE:

Introduction:

Sumner Regional Medical Center (SRMC) is dedicated to providing quality healthcare service to all customers, internal and external. This is accomplished by providing a safe environment, by developing a culture of continuous improvement and engaging all caregivers with the goal of optimal patient outcomes

PURPOSE:

The purpose of the Continuous Quality Improvement (CQI) Plan is to provide an organizational framework and functional strategies to be used in coordinating the design, measurement, assessment, continuous monitoring and evaluation to improve the quality of clinical and operational processes designed to promote health and deliver patient care. The hospital management, through the strategic planning processes, is dedicated to providing the stimulus, the vision and the resources necessary to encourage activities that foster continuous improvement. Efforts undertaken as part of the quality initiatives are the responsibility of the Board of Trustees and hospital leadership including medical staff leaders and medical staff. Clinical risk management, safety management, utilization management and infection control are essential components of the improvement process.

POLICY:

III. Goals

To systematically improve patient health outcomes by:

1. Providing a safe environment for patients as well as visitors and associates.
2. Developing a culture for continual improvement for all
3. Engaging all caregivers including physicians, board members and leadership; and
4. Ensuring optimal outcomes for patients.

IV. Objectives of the Quality Program:

1. Develop, implement and support a structured interdisciplinary process to continuously evaluate the quality, efficacy and efficiency of patient care across the continuum of care and operational services to include satisfaction and financial outcomes;

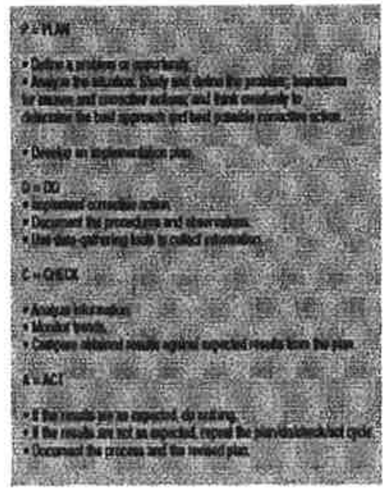
Retrieved 08/05/2015. Official copy at http://lpnt-sumner.policystat.com/policy/1320202/. Copyright © 2015 Sumner Regional Medical Center

2. Ensure a comparable level of quality of care throughout all patient care areas;
3. Establish priorities for improvement having the greatest impact on patient care (high volume, high risk, high cost and problem prone) as well as integrate CQI activities;
4. Ensure priorities for improvement aligned with hospital strategic goals
5. Enhance opportunities for patients to influence the manner in which clinical care and services are delivered through ongoing satisfaction monitoring throughout the hospital. Monitor and resolve complaints in order to enhance the general level of customer satisfaction.
6. Utilize databases for analysis, comparison and identification of hospital-wide opportunities for improvement.
7. Initiate Sumner Quality Guide (SQG) methodology when significant and undesirable patterns or trends occur, with emphasis on reducing risk to patient and improving safety.
8. Utilize the SQG methodology for clinical and operational quality improvement with emphasis toward targeted outcomes and benchmarks;
9. Proactively develop and publish publicly reported data;
10. Identify actual or potential risk in clinical aspects of patient and visitor safety, and minimize the impact on patients and public.
11. Provide education and training in performance improvement principles and applications;
12. Ensure that performance improvement does occur.

PROCEDURE:

SUMNER QUALITY GUIDE

This model provides a framework for the improvement of a process or system. It can be used to guide the entire improvement project, or to develop specific projects once target improvement areas have been identified. The PDCA cycle is designed to be used as a dynamic model. The completion of one turn of the cycle flows into the beginning of the next. Following in the spirit of continuous quality improvement, the process can always be reanalyzed and a new test of change can begin. This continual cycle of change is represented in the ramp of improvement. Using what we learn in one PDCA trial, we can begin another, more complex trial.



P = PLAN

- Define a problem or opportunity.
- Analyze the situation. Study and define the problem; brainstorm for causes and corrective actions; and think creatively to determine the best approach and best possible corrective action.
- Develop an implementation plan.

D = DO

- Implement corrective action.
- Document the procedures and observations.
- Use data-gathering tools to collect information.

C = CHECK

- Analyze information.
- Monitor trends.
- Compare obtained results against expected results from the plan.

A = ACT

- If the results are as expected, do nothing.
- If the results are not as expected, repeat the plan/do/check/act cycle.
- Document the process and the revised plan.

Plan - a change or a test, aimed at improvement.

In this phase, analyze what you intend to improve, looking for areas that hold opportunities for change. The first step is to choose areas that offer the most return for the effort you put in-the biggest bang for your buck. To identify these areas for change consider using a **Flow chart** or **Pareto chart**.

Do - Carry out the change or test (preferably on a small scale).

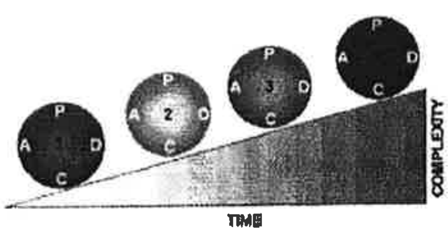
Implement the change you decided on in the plan phase.

Check or Study - The results. What was learned? What went wrong?

This is a crucial step in the PDCA cycle. After you have implemented the change for a short time, you must determine how well it is working. Is it really leading to improvement in the way you had hoped? You must decide on several measures with which you can monitor the level of improvement. Run Charts can be helpful with this measurement.

Act - Adopt the change, abandon it, or run through the cycle again.

After planning a change, implementing and then monitoring it, you must decide whether it is worth continuing that particular change. If it consumed too much of your time, was difficult to adhere to, or even led to no improvement, you may consider aborting the change and planning a new one. However, if the change led to a desirable improvement or outcome, you may consider expanding the trial to a different area, or slightly increasing your complexity. This sends you back into the Plan phase and can be the beginning of the ramp of improvement.



Through this process, knowledge of how a process is currently performing to meet patient/customer needs and expectations is used to plan and implement changes for improvement. This is the recommended model whether working in teams, committees, individuals or as a system-wide function. Although the focus of the program will be on systems/processes, individual performance is part of the process. When improvement activities determine individual performance issues, education will be provided and action taken to modify responsibilities of job assignment if needed.

Structural Framework

The Quality Council (QC), along with the Senior Leaders, will have the responibility to identify the priorities for measurement and improvement which will be aligned with the Hospital Strategic Initiatives and determines the appropriate approach with the following functional areas. The QC will be composed of five functional areas for regular monitoring and reporting of to include:

- Regulatory
- Safety
- Quality Improvement Teams
- Medical Staff Quality Activities
- Departmental Service

A brief synopsis of each is contained below.

Regulatory activities will include Joint Commission, Federal/Center for Medicare/Medicaid (CMS), State of Tennessee and any other accrediting body associated through SRMC. This will include activities with Joint Commission Function Teams, Patient Tracer activities as well as other indicators that fall under accreditation purpose.

Safety will be an organization-wide process designed to reduce medical system errors and hazardous conditions. The organization-wide plan is implemented through the integration and coordination of 2 functions: Clinical and Environment of Care. The two functions will incorporate product and standardization component across both functions. The clinical function will include improvement activities related to medication errors/adverse drug events; Patient safety, to include National Patient Safety Goals with their recommendations along with implementations and compliance; risk management monitoring to include incident reports, root cause analysis of events as well as pro-active assessment methodologies, and events reported to under State of Tennessee statutes.

By utilizing continuous improvement to support a proactive organizational safety climate, the leadership of SRMC strives to achieve a culture free of blame so that staff and physician feel comfortable reporting actual adverse occurrences and risk-laden processes. The patient safety and quality program promotes a non-punitive environment for reporting and follow-up of medical errors coupled with professional accountability. Patient safety is a priority in planning and operations that is reflected in the Quality Plan, the Hospital Plan for Care and in the budget process. National patient safety goals and their recommendations are implemented and incorporated into relevant services provided at SRMC.

The Environment of Care function will include the monitoring and improvement activities related to Environment of Care chapter with The Joint Commission as well as Quality Control activities. Associate safety will include improvement activities related to associate injuries/illnesses, blood and body fluid exposures as well as Workman's Comp and will report up through Environment of Care.

The Patient Safety/Clinical Quality (PSCQ) Committee will evaluate opportunities to better patient care and services as well as hospital operating processes. They involve two or more departments and have estimated team longevity of at least six months. Opportunities will be identified at all levels in the organization, and approved by Senior Leadership. Lean healthcare activities as well as the PDCA model, and other process improvement tools will be used to obtain optimal outcomes.

Departmental activities will incorporate set priorities with Senior Leadership and Directors of each department as well as operational improvement efforts.

The service process interfaces with this quality plan for areas for improvement that go beyond patient related subjects to include patient satisfaction, associate satisfaction, patient advocacy, as well as physician satisfaction. It will be considered performance improvement in the broadest sense.

Medical Staff Quality Activities will be explained further in this plan.

Authority

1. Quality Council (QC) will create a clear Quality vision for all employees; monitor interdisciplinary team activities to avoid duplication and focus on systems and processes; set priorities and reprioritize for evaluation based on high risk high volume and problem prone; to promote continual improvement in clinical and operational processes; establish and prioritize Quality Improvement Goals; formulate Quality Improvement implementation strategies and plans aligned with the Hospital's design.
2. QC shall have the authority to direct the PSCQ Committee to complete studies and forward findings to appropriate channels for problem resolution; decision making mechanisms to facilitate the Qualtiy Improvement process; develop a comprehensive Quality Improvement training program based on the educational needs of clients/customers, managers, employees, physicians, and other key constituents; to use clinically valid criteria appropriate study procedures and relevant clinical reference data bases for effective assessment evaluation and comparison; and receive reports of all CQI activities.

Membership

1. SRMC Senior Leaders
2. Medical Staff Quality Committee (MSQC) Chair and/or designee
3. Quality Director
4. Risk Manager
5. Representative from the SRMC Board

The Quality Council shall delegate the responsibility for coordination and management of data collection, display and integration to the Hospital's Quality Management Department. The Quality Management Department shall be the single repository for coordination of all quality improvement activities within the Medical Center.

Medical Staff Quality Committee (MSQC)

The Medical Staff Quality Committee receives, reviews and makes recommendations on the quality activities of the following medical departments and committees:

Committees

- Blood Utilization Committee
- Pharmacy and Therapeutics Committee
- Critical Care Committee
- Infection Control Committee

- Cancer Committee

Medical Staff Departments

- Department of Emergency Medicine Quality Committee
- Department of Surgery Quality Committee
- Department of Family Practice/Medicine Quality Activities Committee
- Department of Obstetrics and Pediatrics Quality Activities Committee
- Department of Diagnostic Medicine Quality Activities Committee

The Medical Staff Quality Committee (MSQC) is composed of representatives from the Medical Staff Departments appointed by the Chief of Staff and reports to the Medical Executive Committee. The Executive committee delegates this function to the MSQC but retains responsibility for Quality functions.

Accountability

A. Board of Trustees

The Board has ultimate responsibility for Performance Improvement by requiring and supporting the mission and vision as well as the objectives of the Quality Program. The Board delegates the authority and accountability to perform this function to the Medical Staff Quality Committee and the Quality Council for both clinical and operational aspects. The Trustees will assess the Quality Improvment program's efficiency and effectiveness, and provide direction through the development of both short and long term priorities for continuous improvements, which are coordinated with Hospital Administration. The Board receives and reviews periodic reports of the findings, actions and results of actions from the Quality Council as well as The Medical Staff Quality Committee.

B. Leadership

Senior Leadership, following the guidance and direction of the Board of Trustees, will set priorities and reprioritization with a multifaceted organizational process that identifies areas of focus for the organization. These areas are Service, People, Quality, Financial, Growth, and Community. Criterion for the individual priorities will be set with those measures that:

- Affect a large percentage of patients (high volume)
- Place patients at risk if not performed well, or if not performed when indicated (high risk)
- Have been or likely to be problem prone
- Affect patient safety and present potential risk to patients as well as to the organization.

Priority setting and reprioritization of priorities is sensitive to emergent needs and is adjusted in response to unusual or urgent needs. Emergent needs are identified through data collection and assessment, changing regulatory requirements, significant patient and staff needs, changes in environment of care, or changes in the community. Once the annual priorities are set organizationally by Senior Leaderhsip and approved by the Board of Trustees, departmental goals are idenified for each pillar.

Confidentiality

All information obtained through performance improvement activities that is considered sensitive or related to patient privacy is to be held in confidence. The identity of patients or practitioners is to be protected. Confidentiality of physician peer review documents is protected according to T.C.A. 68-11-272. These records are maintained in the Quality Management Department.

Annual Evaluation

The Quality Council and Medical Staff Quality Committee shall prepare with coordination through the Quality Management Department an annual evaluation of performance improvement process and re-prioritizing indicators for the following year. The report will be submitted to the Executive Committee of the Medical Staff as well as to the Board of the Trustees. The members of the Quality Council will evaluate their contribution and effectiveness in relation to the Continuous Quality Improvement Activities.

Attachments:

Image 1
Image 2
Quality Committee Structure

Committee	Approver	Date
Policy and Procedure	Mitzi McCloud: Nursing Director	08/2014
Trustees	Amy Ray: Admin. Asst.	08/2014
Administration	Susan Peach: CEO	09/2014
Policy and Procedure	Tara Shivers: Nursing Director	02/2015
	Susan Peach: CEO	03/2015
Trustees	Amy Ray: Admin. Asst.	03/2015

Tab 18

Attachment C
Contribution to the Orderly Development of Health Care – 5

Utilization Review Plan

SUMNER Regional Medical Center
HIGHPOINT HEALTH SYSTEM

Effective:	08/2015
Approved:	08/2015
Last Revised:	08/2015
Expiration:	08/2018
Policy Area:	*Case Management*
Applicability:	*Sumner Regional Medical Center*

Utilization Management Plan

Scope:

Hospital wide

INTRODUCTION

In accordance with the requirements of the Health and Human Services Conditions of Participation, Centers for Medicare and Medicaid Services (CMS) guidelines and Standards of the Joint Commission on Accreditation of Healthcare Organizations, Sumner Regional Medical Center Governing Board delineates its Plan for Utilization/Resource Management. The Plan contains references to both Utilization Management and Case Management. Case Management applies to the staff and committee responsible for the Utilization Management Program and reflects the broader scope of efforts to effectively manage resource utilization. Utilization Management reflects the actual process of reviewing patient care. This plan has been developed and approved by the Utilization Management Committee, the Medical Executive Committee, and the Board of Trustees.

I. Authority

The Board of Trustees has the ultimate responsibility for review of the quality, appropriateness and medical necessity of admissions, continued stays, and supportive services. It delegates specific functions to the Medical Staff to develop and implement a comprehensive Utilization/Resource Management Plan. The authority and responsibility for providing personnel, resources, and equipment has been delegated to the Administrator of Sumner Regional Medical Center.

The Medical Staff and Board of Trustees' approval of the Plan verifies acknowledgement of this responsibility. The Utilization/Resource Management Plan is under the direction of the Utilization Management Committee. The Utilization Management Committee shall review and approve the Plan annually for scope and objectives.

II. Purpose

The purpose of the Utilization/Resource Management Plan includes:

- To assess and improve the delivery of quality care to all patients, regardless of payment source, and in an efficient and cost-effective manner.
- To delineate the methods for conducting reviews of appropriateness and medical necessity of admission, appropriateness of setting (level of care), duration of stay / continued or extended stays, day and cost

outliers, supportive services, professional services furnished including drugs and biologicals and discharge planning.

- To assist in the promotion and maintenance of high quality care through analysis, review, and evaluation of clinical practices within the Hospital.
- To assure continuity of patient care. Address over/under utilization and scheduling of resources.
- The appropriateness, clinical necessity, and timeliness of support services provided directly by the Hospital, or through referral contracts through concurrent review.
- To assure the efficient utilization of beds and services through admission, concurrent and retrospective reviews of the medical necessity for inpatient admissions, appropriate care setting/level of care, appropriate length of stay, outlier cases (extended stay or high cost), and timely and appropriate use of diagnostic and therapeutic services.
- To assure cooperation and support from all review organizations in measuring the utilization and quality services.
- To assure the medical record substantiates through clear documentation the quality and utilization of services needed for the management and progress of each patient.

III. Utilization Management Committee

A. Organization

The Committee will be composed of two (2) or more physicians of the Active Staff, representing the admitting services of the medical staff, and assisted by other professional personnel. The Physician Advisor will be a member of the Committee. All medical staff committee members shall be appointed by the Chief of Staff. Appointment shall be for one year.

Representatives from Administration, Medical Records, Case Managers, Quality Improvement, Pharmacy, and Nursing may attend Committee meetings. When the committee makes a physician recommendation, the decision of practice considerations will be referred to the Medical Executive Committee for action where collaboration can occur between the Medical Staff Leaders.

Upon invitation from the Chairman, other representatives of the Hospital or Medical Staff may attend meetings. The Chairman and other designated Members of the Committee shall serve, as Physician Advisor if there is not an appointed advisor available. The Physician Advisor (whether internal or external) will function as an extension of the Utilization Management Committee.

B. Responsibilities

The responsibilities of the Committee include:

- To develop, maintain, and execute an effective Utilization Management Plan; review and revise the Plan annually; and assure the functions required by the Plan are continuously performed and documented in a proper and timely manner.
- To provide efficient utilization of beds and supportive services through concurrent and retrospective reviews of the necessity for inpatient admissions, appropriate duration of stays, and timely and appropriate use of diagnostic/therapeutic services.
- To effect the development of a plan whereby patients receive needed care, delivered in an efficient cost-effective manner. This process assures quality of care in conformity with criteria of optimal use as determined by the medical staff. Any quality concerns identified in the review process are referred to Medical Staff Quality Committee as appropriate.

- To effect the development, maintenance, and execution of the functional elements of the Quality Improvement Organization Program (QIO), to include: admission request and certification, pre-admission request /testing, length of stay review, discharge planning, and retrospective evaluation of performance measured to Medical Staff and nationally approved clinically valid criteria (InterQual® SIM plus, InterQual® discharge screens) or CMS 1599-F 2 Midnight Rules for traditional Medicare.
- To review patterns/profiles generated by the Quality Improvement Organization and Hospital, (such as but not limited to Hospital and Physician LOS compared to GMLOS) to identify opportunities to improve provision of care and to initiate appropriate actions.
- To collaborate in monitoring and analyzing the review activities of non-physician reviewers, and the Hospital appointed Physician Advisor. Medical Staff Department Chairs, if necessary, may function as second level physician reviewers when there is disagreement between the physician reviewer and the attending physician.
- To collaborate in the establishment and approval of criteria, standards, and norms for pre-admission review, admission review, and continued stay review; and to assist in continuing modification of such criteria, standards, and norms. (Allied Health Care Professionals may be involved in development of criteria.)
- To monitor improvements in utilization and resource management following recommendations of corrective actions (such as but not limited to trending compliance with Medicare Important Message, Discharge Appeal Notices, outliers, and denials and 30 day readmissions)

C. Meetings

The Committee shall meet and report to the Medical Executive Committee quarterly or more frequently as needed as determined by the Committee Chair.

IV.Confidentiality

Confidentiality shall be maintained, based on full respect of the patient's right to privacy, and in keeping with the Hospital Policy and the QIO Confidentiality Statement. All employees of or outside agencies that are involved in the review process will be made aware of the responsibility to maintain confidentiality. The records and reports utilized and/or generated by the Committee members are regarded as confidential and both patient and provider privacy will be protected in reports by using coded identification. This Committee is part of the Medical Executive Committee process for, and all records, minutes and reviews are protected under the medical staff peer review process for quality improvement/quality assurance. The Quality Department, under the direction of the Medical Staff, shall be responsible for maintaining all such reports. All data shall be considered the property of Sumner Regional Medical Center.

V. Conflict of Interest

A person may not review a case or make final utilization determination if he/she has, or is perceived to have, a conflict of interest such as having participated in development or executing that patient's treatment plan, or is a member of the patient's family. Physician Advisors may not participate in decisions on cases where the Physician Advisor is the Attending or Consulting Physician, or where the Physician Advisor's partner, associate, or relative is involved in the care of the patient. The Physician Advisor should not participate in any case in which his/her objectivity may be impaired. No member of the Utilization Management Committee may have a financial interest in the facility. It is the responsibility of the member or prospective member to notify the Committee of any such interest.

VI. Plan of Care

The Attending Physician, along with ancillary personnel, will establish a written plan of care for each patient. This is to be completed within 24 hours of admission by the Attending Physician or other designated health care personnel.

This care plan will include the following:

- Diagnosis, symptoms, complaints, and complications indicating reason for admission.
- A description of the functional level of the individual.
- Estimated length of stay
- Orders for medications, therapy, restorative, and / or rehabilitative services.
- Activities
- Diet
- Plans for continuing care, as appropriate.

Orders and activities must be developed in accordance with physician instructions. Orders and activities will be reviewed and revised as appropriate by all personnel involved in the care of the patient.

VII. Methods of Review/Review Process

A. Who Shall Perform Reviews

- The reviews falling under this Utilization Management Plan for patients in the acute inpatient or outpatient care setting shall be conducted concurrently and/or retrospectively by the Director of Nursing, Nursing Supervisors, Case Managers, Outpatient Case Managers, the Physician Advisor, and Department Chairs and/or by the Utilization Management Committee.
- Commercial insurers who request access to medical records for review purposes must present signed consent forms in the Medical Records Department if the patient has been discharged. If the patient remains in-house, the Case Management Department will verify the patient's insurance company, as designated on the face sheet and / or interview with patient and ensure information matches the name of the insurance company that the reviewer is representing.

B. Criteria

The Case Managers shall use the prescribed and authorized criteria designated by Medical Staff, McKesson InterQual ® while reviewing the severity of illness, intensity of service and discharge screens. InterQual ® Criteria is utilized at Sumner Regional Medical Center. In the case of the traditional Medicare beneficiary, all elements of 1599-F 2 Midnight Rule are enforced and required prior to hospital discharge.

C. Selection of Patients to be Reviewed

Categories of patients subject to review will be evaluated for medical necessity and appropriateness and continued stay in acute inpatient and/or outpatient care settings of the hospital.

Patients to be reviewed concurrently include:

- Hospital inpatients, bedded outpatients and outpatient observation status patients. Patients requiring discharge planning assistance from the Emergency Department and Ambulatory Surgery setting will be reviewed as needed, regardless of payor source.

- Any patient where an identified concern is brought to the attention of utilization/case management personnel from any healthcare provider/representatives.
- Patients requiring procedures that are not available at Sumner Regional Medical Center – thereby requiring transfer to another facility for the procedure(s).
- Patients under a targeted DRG, diagnosis, procedure, or focused physician review, as designated by the Sumner Regional Medical Center – Utilization Management Committee or Sumner Regional Medical Center – Patient Safety/Clinical Quality Committee.
- Patients falling under a targeted DRG, diagnosis, procedure, or focused physician review, as designated by the Sumner Regional Medical Center –Utilization Management Committee or Patient Safety/Clinical Quality Committee will be subject to more frequent review.

D. Pre-Certification

In accordance with Centers for Medicare and Medicaid Services regulations and other third party payers, pre-admission certification is carried out on scheduled admissions through the designated Business Office, prior to or at the time of admission. Non-scheduled admissions admitted through the Emergency Department will be reviewed by the Case Managers. Utilization/Case Management personnel will assist, as needed, in the pre-certification process. Nursing staff or a qualified outside contractor may be solicited for after hours and weekend pre-admission review.

E. Admission Review

Inpatient and outpatient observation status will be reviewed for appropriateness of in-hospital care. In accordance with CMS-1599-F ruling, inpatient admission for a Medicare beneficiary requires an order that states "inpatient" as part of the language for inpatient services. The inpatient order must be signed, dated and timed prior to discharge. In accordance with current CMS guidance, if the order is not valid or countersigned by a physician with hospital admitting privileges prior to discharge, then no inpatient stay occurred.

The Case Manager, using appropriate "Acute" or "Observation" criteria conducts initial review within 24 hours or one (1) business day of admission. The criteria utilized by the Case Management staff in the review process will be based upon *InterQual ®and Pediatric Screening Criteria* if appropriate for the payer. The admission is screened for medical necessity and appropriateness for level of care. The admission may be justified by either meeting all components of the criteria point in the given subset for managed care payers; or by physician inpatient order where the physician documents the medical need for inpatient admission and it crosses two midnights in the case of traditional Medicare. The patient may also be admitted to inpatient status if the stay is authorized as such, according to individual commercial insurance/managed care guidelines. If the criteria are met, admission is approved. If the admission cannot be certified using criteria, the Attending Physician is contacted by the Case Manager for additional information. If the Case Manager still cannot determine medical necessity, the case is then referred to the Physician Advisor for review. He/she is asked to make a peer determination within 24 hours as to whether hospitalization is medically necessary. The determination of the Physician Advisor will be delivered verbally and in writing to the Case Management Department. (When there is a delay with support services, verbal contact with the appropriate department is made to expedite appropriate utilization.)

If the attending practitioner does not respond or does not contest the findings of the committee or subgroup or those of the physician who performed the initial review, then the findings are final. If the attending physician contests the committee or subgroup findings, or if he presents additional information relating to the patient's need for extended stay, at least one additional physician member of the committee must review the case. The determination of the second member of the committee will be delivered verbally and in writing to the Case Management Department.

If, after two physician members determine the patient's stay is not medically necessary or appropriate after considering all the evidence, their determination becomes final. Written notification of this decision must be sent to the attending physician, patient (or next of kin), facility administration, and the single State agency (in the case of Medicaid) no later than 2 days after the final determination, and in no event later than 3 working days after the end of the assigned extended stay period. (There are only 5 working days in a given week. Normally these days are Monday through Friday, however, when a holiday falls on a working day, that day is not counted as a working day.)

For all Medicare beneficiaries, hospitals must deliver valid, written notice of a beneficiary rights as a hospital inpatient including, discharge appeal rights. The hospital must use a standardized notice, as specified by Centers for Medicare and Medicaid Services.

Medicare Condition Code 44

Condition Code 44 provides for a systematic process for correcting a valid or countersigned inpatient order in cases when a Medicare patient did not meet Medicare inpatient medical necessity, or did not require 2 midnights and did not have current Medicare published exceptions, and did receive medically necessary services that can be appropriately billed as outpatient services. In cases where the hospital's utilization review process by Case Management has determined that an inpatient admission does not meet Medicare's inpatient criteria, the hospital will review the case through its utilization review process to determine if it is appropriate to revise the beneficiary's status from inpatient to outpatient. The Utilization Management Committee must notify the practitioner responsible for the care of the patient to be allowed the opportunity to submit his views and any additional information related to the patients needs for admission. The Physician Advisor may make the recommendation to change a patient to outpatient (observation) status by Condition Code 44 with attending physician concurrence. The Case Manager or other designated personnel will notify the patient or patient's designated caregiver in writing of the determination prior to patient discharge.

In accordance with *Medicare Claims Processing Manual, Chapter 1, §50.3.2, Policy and Billing Instructions for Condition Code 44*, the hospital may not change a Medicare beneficiary from inpatient to outpatient status without involvement of the Utilization Management Committee.

The change in patient status from inpatient to observation can only occur when all the following conditions have been met:

- The change in patient status from inpatient to outpatient is made prior to discharge AND
- The hospital has not submitted a claim to Medicare AND
- The attending physician concurs with the Utilization Management Committee decision AND
- The attending physician's concurrence is documented in the medical record AND
- The is an order to change the status to outpatient (observation)

If any of these conditions are not met, the status must remain as inpatient regardless if stay meets inpatient criteria or the presence of an outpatient observation order. If the status must remain as an inpatient because the elements of Condition Code 44 were not met, the claim must be processed under Medicare Part B only and the patient will be notified in writing within 2 days of the determination. All Condition Code 44 activity will be reported to the Utilization Management Committee with each meeting. All provider liable cases as well as 0-1 day Medicare inpatient stays will be tracked and reported to the UM Committee for ensured compliance with federal regulations, possible trend identifications and any required actions.

Custodial care and medically unnecessary inpatient hospital care

A hospital may charge a beneficiary for services excluded from coverage on the basis of §411.15 (g) of custodial care chapter or § 411.15 (k) (medically unnecessary services) and furnished by the hospital.

When possible, verbal notification will precede written notification. Notification is issued in the form of a Detailed Notice of Discharge, Advance Beneficiary Notice or Hospital Issued Notice of Non-coverage (HINN).

At time of criteria application, the Case Manager will document findings under the appropriate Utilization Review program or other designated program as applicable. If the admission criteria are met, the admission is approved. Admission and subsequent patient reviews will be documented until the patient is discharged from hospital. After discharge, the files will be maintained electronically.

The Case Manager will meet with the patient and/or family to initiate an assessment of the patient's discharge planning needs as determined by screening, evaluation or by request.

Diagnosis/physician concerns, etc. for inappropriate admissions will be presented to the Utilization Management Committee and / or the Physician Advisor acting as an extension of the Utilization Management Committee, by the Director of Case Management, or designee. Appropriate supporting data shall be obtained through retrospective profile monitoring. If such areas are identified, methods for their correction or prevention will be considered by members of the Utilization Management Committee, including selection of diagnosis and/or physicians for focused reviews.

F. Concurrent/Continued Stay Review

Once the admission is approved, continued stay reviews will be performed by the Case Managers no less than:

- Every 3 business days from the previous review date, until the time of patient discharge.
- Additionally, when problems/trends are identified, day outliers (14 day or greater LOS) or cost outliers are identified that warrant a more focused review, or as required/requested by regulatory agencies and individual commercial insurance standards.

The Centers for Medicare and Medicaid Services Geometric Length of Stay (GMLOS) by DRG as published in the Federal Register will be used as a guideline for length of stay comparisons.

Patient charts shall be reviewed for the level of service, resource consumption and need for continued hospitalization. The continued hospital days will be reviewed using appropriate criteria as specified in this plan. If the discharge screens are not met, the hospital day will be considered justified. Discharge screening criteria are considered met, when there is documented evidence the patient is stable and can safely be discharged to an alternate level of care.

If it becomes apparent that further hospitalization is not justified, the reviewer shall contact the attending physician. If the attending physician agrees, he/she shall discharge the patient. If there are undocumented factors justifying continued stay, the attending physician shall provide documentation and the stay shall be justified. If the attending physician concurs that further hospitalization is not justified, but the patient objects to the discharge, the Case Manager shall provide to the patient (and or his representative) a detailed notice describing the right to an expedited determination by the QIO. The designated hospital personnel will deliver the detailed notice to the beneficiary as soon as possible but no later than noon of the day after the QIO's notification. A copy will be sent to the attending physician, Administrator, the Business Office, the CFO, the QIO or its specified designee, and the Director of Nursing on the same day the decision is made.

If the discharge screens are met but the attending physician does not agree to discharge the patient, the process of referral to the Physician Advisor is the same as for admission review.

If the Physician Advisor considers the continued stay to be inappropriate and the attending physician is not in agreement, the case is automatically referred to a second Physician Advisor or to the Department Chairman for a second opinion. A continued stay denial will not be issued without the agreement of two physicians. If, after review by the second physician, a determination is made that a denial is appropriate, the Case Manager will notify the patient or family, attending physician, Hospital Administration, Business Office, and QIO. Written notification shall include appeal rights.

In cases where the Physician Advisor determines that a Medicare denial is appropriate, he/she will contact the attending physician. If the attending physician is not in concurrence with the denial, a second Physician Advisor or Department Chairman will be asked to review the case. If the second physician agrees to the denial, Detailed Notice of Discharge process is implemented. Copies will be sent to the attending physician, Hospital Administration, patient and/or next of kin, and the QIO.

The Detailed Notice of Discharge does not mandate that the patient must leave the hospital. It only means necessity for hospitalization will cease on noon the day after the QIO makes the appeal determination notice is issued.

G. Review of Individual Days of Care

1. Delays in Care, Inefficient Scheduling of Resources

Utilization related concerns including delays in supportive services, are identified through both the Case Management's pattern analysis, and the quality assessment and improvement process.

During the continued stay review process, monitoring will occur for Avoidable Days (i.e., problems with delays/ unavailability of hospital services, delays in test results, social or placement problems, missed orders, delays attributed to physician convenience, preference, etc. that lead to unnecessary days of hospitalization and/or delays in care/treatment). This information will be documented by Case Managers. Avoidable Days will be analyzed by the Case Management Director for patterns or trends. This information will be reported to the Utilization Management Committee, hospital departments, and the CFO for appropriate measures to improve process.

2. Under Utilization of Services

Under utilization of services will be screened by the Case Managers during the review process.

Patient records will be screened for patient care services that are needed and not ordered or ordered and not performed. The reviewers will monitor follow-up on abnormal test results and appropriate unit placement. When concerns are identified, the Case Manager will notify the Physician Advisor for immediate intervention.

Re-admissions within 31 days with the same DRG, or the diagnosis of MI, CHF, pneumonia, and COPD will be reviewed for inappropriate discharge on first admission or complications as a result of the original discharge plan. The Case Managers will monitor daily for new admissions that were discharged within the preceding 31 days. As patterns/trends are identified, they will be reported to the Utilization Management Committee, MEC and Governing Board for performance opportunity.

The Case Managers will concurrently review records to assure discharge screens are met prior to patient discharge. If screens are not met and a discharge order is written, the attending physician is contacted. If necessary, the Physician Advisor will assist with intervention. The Director of Case Management will compare data to peer norms to identify any pattern of under utilization or quality of care issues by physician, diagnosis or DRG.

3. Appropriateness of Services

At Utilization Management Committee meetings, appropriateness review of designated high volume radiology, cardiopulmonary, laboratory, drugs and biologics services will be reported. Each department director or designee will report the findings of their review activities to the Committee with concerns and recommendations for improvement.

4. Data Collection, Analysis and Reporting

The Case Manager will be responsible for the collection of data to support concurrent review, patient care evaluation studies, and profile analysis. The patient record will include information needed for the Committee to perform utilization review:

- Identification of the patient.
- The name of the patient's physician.
- Date of admission / readmission.
- The plan of care required.
- Initial and subsequent continued stay review dates (SI/IS and Discharge screens).
- Procedures and dates.
- Justification of emergency admission if applicable.
- Discharge planning.
- Discharge diagnosis.
- Discharge disposition.
- Physician Advisor activity.
- Other supporting material as requested by the Committee

Data shall be gathered manually or electronically for admission certification and extended stay reviews. Review worksheets / screens shall serve as the data collection tool. Data from the review form / screen will be entered into the Case Management Program for reporting purposes. Reports will be taken to the Utilization Management Committee for review, recommendations, actions and follow up. These and other computer-generated reports are evaluated to detect patterns of inappropriate utilization and evaluate changes in practice patterns. Summary reports of collected data will be given to the Utilization Management Committee for evaluation, recommendation and action.

5. Medicaid Certification and Re-Certification

The need for inpatient services for Medicaid patients must be certified as per State specific Medicaid requirements. Medicaid patients are reviewed the same as all other reviewed patients.

Re-certification must be made as requested by Medicaid.

VIII. Discharge Planning

The process of discharge planning begins prior to or within 24 hours of admission for all bedded patients. The admitting nurse or Case Manager screens patients to assess their potential post-hospitalization needs. They work with attending physicians, patients, and families to assure continuity of care after discharge. Sumner Regional Medical Center maintains an open referral system so that the initiation of discharge planning is not delayed. Screening and discharge referrals also occur from other health care professionals such as nursing and other ancillary services utilizing high risks screening criteria.

The Case Manager and or nursing personnel assess discharge-planning needs within one business day of the patient's admission and initiates discharge planning for nursing home or rehabilitation placement, durable medical equipment, home health care, hospice or transportation as needed. Discharge planning activities include provisions for, or referral to, services required to improve or maintain health status following discharge. Important factors considered for discharge planning include but are not limited to; functional status, cognitive ability of the patient, bio-psychosocial needs, patient and caregiver's understanding of discharge needs, identification of post-hospital care resources and family support.

During the process of concurrent review, the Case Manager will reassess discharge-planning needs as necessitated by changes in patient's condition/ family preference. The Case Manager assists those patients in need of additional resources, including, but not limited to financial assistance, emotional support, counseling, Medicaid and guardianship programs. All discharge planning activities will be clearly documented in the patient's medical record.

The patient will be notified of and afforded the right to participate in the development and implementation of his or her plan of care. The patient or his /her representative (as allowed under State Law) will be afforded the right to make informed decisions regarding his/her care and being involved in care planning and treatment.

Sumner Regional Medical Center will produce a Patient Choice list of HHAs, Rehabilitation or SNFs that are available to the patient, that are participating in Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF in the geographic are requested by the patient. HHAs must request to be listed by the hospital as available.

The lists will be presented to patients for who home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

For patients enrolled in managed care organizations, Sumner Regional Medical Center –will indicate the availability of home health and post hospital extended care services through Individuals and entities that have a contract with the managed care organizations.

Documentation that the list was presented to the patient and or individual acting in the patient's behalf will be placed in the medical record by Sumner Regional Medical Center –Case Management staff.

Disclosure information will be provided to the patient and documented in the patient medical record in which Sumner Regional Medical Center –has a financial interest

Transfer or Referrals require Medical information be released only to authorized individuals to ensure the patient receives proper post-hospital care. In instance in which the patient refuses transfer Sumner Regional Medical Center - Case Management staff will document the patient refusal in the discharge plan of the medical record.

IX. Committee Reports and Records

The Utilization Management Committee shall maintain the minutes and records of each Committee meeting and will include the actions taken regarding the admission or continued stay of any patient reviewed, and the reasons for such actions. The Committee will report on identified trends associated with over-utilization, under-utilization, and inefficient scheduling of resources. Copies of such reports and records shall be made available to the Committee members, the Hospital CEO, and the Medical Executive Committee. The Utilization Management Committee shall make a summary report to the Medical Executive Committee and Governing Board quarterly.

The Director of Case Management shall be responsible for maintaining individual and aggregate data with respect to the reviews of acute care patients. He/she shall be responsible for distribution of the reports to appropriate individuals. The Utilization Review process is conducted as part of the Quality Improvement/ Quality Assurance program of the Medical Staff and Hospital. The Case Management Department will maintain copies of all worksheets, and other data. All utilization review findings shall be considered confidential.

X. Developing A Corrective Plan Linking the Results to Continuing Medical Education

When Medical Staff performance improvement opportunities are identified through concurrent review, recommendations for action shall be the responsibility of the Medical Staff and shall be documented as part of the continuing education function.

XI. Relationship to Third Party Payers

The Hospital is responsible through the Case Management function for the process of receiving and presenting claims to third parties, including the fiscal intermediary, the basis upon which payment is allowed by the intermediary, the conditions under which the intermediary denies claims, and the claims appeal data about a case shall be open to review by fiscal intermediaries, state agencies, and the QIO. Information and data shall be protected to assure confidentiality.

XII. Hospital Administration

The Hospital Administration shall provide assistance to assure the proper functioning of the Case Management Program and that information is properly assembled, forms are provided, and by providing secretarial assistance and meeting space, and by acting as liaison with all departments. Administration shall be responsible for considering and acting upon decisions and recommendations stemming from the Case Management function with respect to Hospital policy, procedures, and staffing.

XIII. Physician Advisor and Review Personnel

A designated Physician Advisor will be available daily, Monday through Friday, to communicate with the Case Managers regarding questionable admissions, quality of care issues, day or cost outliers and continued stay cases. This communication will be in person and/or via telephone as necessary. Other members of the Utilization Management Committee or Department Chairs will provide assistance when the Physician Advisor is not available. The Case Managers will seek specific assistance and advice from the Physician Advisor in the following situations:

- When the Case Manager has reason to believe that an admission, continued stay, or ancillary service is not medically necessary based on criteria.
- When the Case Manager is unable to make a decision as to whether there is medical necessity for acute care, even when guidelines are met.
- When there is a question of quality of care being rendered.
- To assist in the implementation of discharge planning when delayed by either the patient, family, and/or attending physician.
- To intervene with the Attending Physician when under/over utilization and quality concerns are identified, as well as delays in services.

The Physician Advisor has authority to initiate denial of an admission or extension of length of stay (pending QIO review and concurrence when required).

In most instances, the Physician Advisor shall render a decision within twenty-four (24) hours as to the approval or denial of an admission or continued stay. The Director of Case Management under the direction of the Administrator shall oversee review activities. Case Management review shall be conducted by personnel qualified to follow directives of the Utilization Management Committee and to apply clinical guidelines and regulations. Sufficient qualified reviewers will be assigned to meet the requirements of reviews.

XIV. Collaboration with Risk Management

During the concurrent review process, the Case Managers will screen patient records for Risk Management concerns (i.e., falls, potential liability issues, infections, possible safety issues, etc.). If concerns are identified through the review process, they will be documented on the case management worksheet and entered into the performance improvement documentation process. When concerns are identified, the Risk Manager will be notified verbally, electronically or in writing and will investigate and take appropriate action with the Hospital Administrator and/or the Medical Staff.

XV. Collaboration with Medical Staff Quality Committee Council and/or the Medical Staff

Case Management is one of the components of a hospital Quality Improvement Program. During the course of concurrent and retrospective review, the Case Managers will screen patient records for quality concerns, including those specific events designated by the Quality Management andRegulatory Compliance Director. If concerns are identified through Case Management review, they will be documented on the case management worksheet. Case Management and Quality Improvement functions will be integrated as follows:

Quality concerns are referred to the Quality Management and Regulatory Compliance Director for review by the appropriate Medical Staff review committee.

If a potential objective or evidence-based quality of care issue is identified during the review process and is considered to be of immediate need for correction, it will first be addressed with the attending physician and, if necessary, will be referred to the Physician Advisor. He/she will review the patient's medical record and call the attending physician or the Hospital Department Manager for discussion of the issue. If the attending physician or Hospital Department Manager is unwilling to correct the problem to the satisfaction of the Physician Advisor, the Chairperson of the attending physician's department, Chief of Staff or Administration will be immediately notified; Administration and the Risk Manager may also be notified.

If a potential quality issue is identified, however, and correction has already occurred, the case will be referred to the Quality Management and Regulatory Compliance Director for referral to the appropriate Medical Staff Committee or Department Manager.

Problem Diagnosis Related Groups (DRG's) will have Quality Improvement Teams assigned to evaluate the problem, determine the cause, and recommend corrective action.

If the Quality Management and Regulatory Compliance Director or the Utilization Management Committee identifies a utilization-related problem, this should be relayed to the Hospital Quality Committee. For more information on the relationship, refer to the Quality Improvement Plan.

Sumner Regional Medical Center –discharge planning process is integrated into its QAPI program. Ongoing discharge planning process assessment will include:

Retrieved 08/07/2015. Official copy at http://lpnt-sumner.policystat.com/policy/1717923/. Copyright © 2015 Sumner Regional Medical Center

- Time effectiveness of the criteria to identify patients needing discharge plans;
- Quality and timeliness for discharge planning evaluations and discharge plans;
- Hospital discharge documentation and information to advise patients and their representatives of appropriate options and;
- Information on a coordinated discharge planning process that integrates discharge planning with other functional departments, including the quality assurance and utilization review activities of Sumner Regional Medical Center –;
- Review of hospital policies and procedures related to reassessment of discharge planning process and
- Adequacy and effectiveness of Sumner Regional Medical Center –discharge process and execution.

XVI. Revision and Review

The Utilization Management Plan shall be reviewed annually by the Utilization Management Committee and revised as necessary. The Medical Executive Committee of the Medical Staff and the Board of Trustees of the Hospital will approve any revision.

Attachments:

No Attachments

Committee	Approver	Date
	Jennifer Holder: Director	08/2015
Policy and Procedure	Tara Shivers: Nursing Director	08/2015
	Anne Melton: CNO	08/2015
MEC	Tammy Carter: Medical Staff Services Manager	08/2015
Trustees	Amy Ray: Admin. Asst.	08/2015

Tab 19

Attachment C
Contribution to the Orderly Development of Health Care – 5

Patient Rights and Responsibilities

SUMNER REGIONAL MEDICAL CENTER

Patient Rights and Responsibilities

We consider you a partner in your hospital care. You can help make your care as effective as possible when you are informed about your condition, participate in treatment decisions and communicate openly with the physician and other healthcare professionals.

All hospital personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patient rights.

Patient Rights

Patients have the right to:

Considerate, respectful care in a safe setting with recognition of their personal dignity and free from all forms of abuse or harassment.

Impartial access to treatment regardless of race, color, national origin, religion, sex, sexual orientation, gender identity, disability, age or source of payment for care.

Personal and informational privacy and confidentiality as permitted by law. Written permission is obtained before the medical records may be made available to anyone not directly concerned with your care.

Access information contained in the clinical records within a reasonable time frame.

Know which physician is primarily responsible for coordinating your care and to obtain information concerning your diagnosis (to the degree known), treatment, outcomes of care (including unanticipated outcomes) and any known prognosis in terms you can understand.

Be told of realistic care alternatives when hospital care is no longer appropriate.

Participate in the consideration of ethical issues that arise in the provision of your care.

Designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient.

Visitors are not denied privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability.

Designate a representative who may be involved in the patient's care planning, discharge planning, and pain management. This representative shall receive a copy of the Patient's Rights.

Designate a support person, who may or may not be the same person as the patient's representative.
Have your rights apply to the person who may have legal responsibility to make decisions about medical care on your behalf.

Reasonable, informed participation in decisions involving your health care. Receive as much information about proposed treatment or procedures as you may need in order to give informed consent or to refuse the course of treatment. *Except in emergencies*, this information shall include a description of the procedure or treatment, the significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name and professional status of the person who will carry out the procedure or treatment.

Know the names and professional relationships of other physicians and healthcare providers who will see you.

Prepare Advanced Directives and appoint a surrogate to make health care decisions on your behalf and have hospital staff and practitioners comply with these directions.

The right to consent to or refuse recommended treatment as permitted by law. If patients or their legally authorized representatives refuse treatment, preventing the provision of appropriate care in accordance with professional standards, the hospital may terminate the relationship with the patient upon reasonable notice. Patients have the right to be informed of the medical consequences of their refusal.

At your own request and expense, consult with a specialist.

Not be transferred to another facility or organization unless you have received an explanation of the need for the transfer, the alternatives to such transfer, and unless the transfer is acceptable to the other facility.

Be informed by the physician responsible for your care of continuing health care requirements following discharge from the hospital.

Request and receive, regardless of the source of payment for your care, an itemized bill for services rendered in the hospital. Patients have the right to a timely notice prior to termination of eligibility for reimbursement of any third-party payer for the cost of care.

Exercise cultural and spiritual beliefs that do not interfere with the well being of others or the planned course of medical therapy for the patient.

Appropriate assessment and management of pain.

Be free from the use of seclusion or restraint, of any form, as a means of coercion, discipline, convenience, or retaliation by staff.

Reasonable responses to any reasonable request you may make for service.

Expect the hospital to provide an interpreter when patients do not speak or understand English or need American Sign Language services.

The hospital involves parents and/or legal guardians for the infant, children, or adolescent patients throughout the course of treatment and provides any of the above described privileges and information to the parents and/or guardians.

Information about the hospital rules and regulations applicable to your conduct as a patient.

Patients are entitled to information on the hospital's process for the initiation, review, and resolution of their complaints, including the quality of care that you receive or if you feel the determined discharge date is premature. A patient may file a complaint or grievance without compromising care.

At Sumner Regional Medical Center, the Department Director is responsible for handling patient and family concerns. Complaints should first be filed with the appropriate Director or shift supervisor of the area where the issue occurred. However, complaints and grievances may also be filed by calling 615-328-5537.

You have a right to file a quality of care concern with your insurance company to further investigate on her behalf.

You may also file a quality of care complaint with the:

Department of Health Division of Health Care Facilities Centralized Complaint Intake Unit at 665 Mainstream Drive, Second Floor Nashville, TN 37243 1-877-287-0010	or	Office of Quality and Patient Safety The Joint Commission One Renaissance Boulevard Oakbrook Terrace, Illinois 60181 E-mail: complaint@jointcommission.org Fax: 630-792-5636

The State of Tennessee is graced with some of the finest health care professionals and treatment facilities in the United States. The majority of healthcare providers in Tennessee are competent and caring individuals, and most people are satisfied with the level of care they receive. However, when a problem is experienced with a practitioner, you have the right to report him/her. If you believe that a healthcare provider's performance or behavior is not acceptable, you may file a complaint through Health Related Boards, Office of Investigations. Issues that are not within Board Authority: Fees and/or billing disputes (amounts charged for services, overcharges, etc). You may visit the following website to download a complaint form (PH-3466) http://health.state.tn.us/boards/complaints.htm or Contact Consumer Affairs at 1-800-342-8385.

Patient Responsibilities

You have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medication, and other matters relating to your health.

You and your visitors have the responsibility to report unexpected changes in condition to the responsible healthcare provider.

You are responsible for reporting whether you understand the treatment plan and what is expected of you.

You have the responsibility to question the hospital staff if a procedure or treatment does not seem appropriate.

You are responsible for following the treatment plan recommended by the healthcare provider primarily responsible for your care.

You are responsible for your actions if you refuse treatment or do not follow the healthcare provider's instructions.

You are responsible for assuring the financial obligations for your healthcare are fulfilled as promptly as possible.

You are responsible for following rules and regulations affecting patient care and conduct.

You are responsible for being considerate of the rights of other patients and healthcare workers and for assisting in the control of noise and the number of visitors.

You are responsible for being respectful of the property of other persons and of the hospital.

You are responsible for adhering to the Tobacco Usage Policy. No smoking is permitted in the hospital buildings or on the adjacent property in compliance with State law.

You are responsible to discuss pain relief options and to develop a pain management plan with the doctors and nurses.

You and your family members have the responsibility to report perceived risks in patient care.

You are responsible for securing personal belongings and valuables.

You are responsible for recognizing the effect of your lifestyle on your personal health. Your health depends not just on your hospital care, but on decisions you make in your daily life.

SUMNER
Regional Medical Center
HIGHPOINT HEALTH SYSTEM

Effective:	*05/2010*
Approved:	*05/2015*
Last Revised:	*05/2015*
Expiration:	*05/2018*
Policy Area:	*Hospital-wide Patient and Visitor Services*
Applicability:	*Sumner Regional Medical Center*

Patient Rights and Responsibilities, C-358

SCOPE:

All facilities and departments affiliated with Sumner Regional Medical Center including but not limited to in-patient services, home health agency, physician practices and out-patient services.

PURPOSE:

Sumner Regional Medical Center maintains that basic individual rights for independence of expression, decision, action and concern for personal dignity and human relationships are of great importance. During sickness the presence or absence of these rights becomes a vital, deciding factor in survival and recovery, therefore, Sumner Regional Medical Center considers it a prime responsibility to assure that these rights are preserved for our patients.

In providing care, Sumner Regional Medical Center has the right to expect behavior on the part of patients and their relatives and friends, which considering the nature of their illness, is reasonable and responsible.

POLICY

The Patient Rights and Responsibilites are as described in the Form provided to the patient (Attachment).

REFERENCES:

*Centers for Medicare and Medicaid Services Hospital Conditions of Participation: Patient's Rights 482.13, as amended
*The Joint Commission Standard for Rights and Responsibilities of the Individual RI.01.01.01

Attachments:

Patient Rights and Responsibilities

Committee	Approver	Date
	Stacey Crudup: Ethics and Compliance officer	02/2015
Policy and Procedure	Tara Shivers: Nursing Director	02/2015
MEC	Tammy Carter: Medical Staff Services Manager	03/2015
Trustees	Amy Ray: Admin. Asst.	05/2015

Tab 20

Attachment C
Contribution to the Orderly Development of Health Care - 7.(b)

The Joint Commission Documentation

Sumner Regional Medical Center
Gallatin, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

September 15, 2012

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #: 7832
Print/Reprint Date: 01/08/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Standard	Standard Text	Total EPs	Addressed 45 Day EPs	Chapter Owner
MM.04.01.01	Medication orders are clear and accurate.	1	0	Tommy Cothron
NPSG.03.04.01	Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.	1	0	Becky Grant
UP.01.03.01	A time-out is performed before the procedure.	1	0	Becky Grant
ESC 60 Day				
Standard	**Standard Text**	**Total EPs**	**Addressed 60 Day EPs**	**Chapter Owner**
EC.02.05.09	The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.	1	0	Mike Messer
LS.02.01.20	The hospital maintains the integrity of the means of egress.	1	0	Mike Messer
LS.02.01.35	The hospital provides and maintains systems for extinguishing fires.	1	0	Mike Messer
MM.03.01.01	The hospital safely stores medications.	1	0	Tommy Cothron
MS.08.01.03	Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.	1	0	Stacey Crudup/Tammy Carter
PC.01.02.03	The hospital assesses and reassesses the patient and his or her condition according to defined time frames.	1	0	Anne Melton/Penny Clark
PC.01.03.01	The hospital plans the patient's care.	1	0	Anne Melton/Penny Clark
PC.03.05.03	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.	1	0	Anne Melton/Penny Clark
RC.01.01.01	The hospital maintains complete and accurate medical records for each individual patient.	1	0	Jon Koederitz
RC.02.03.07	Qualified staff receive and record verbal orders.	1	0	Jon Koederitz

Sumner Regional Medical Center

Organization ID: 7832

555 Hartsville PikeGallatin, TN 37066

Accreditation Activity - Measure of Success Form

Due Date: 4/4/2013

HAP Standard MM.04.01.01 Medication orders are clear and accurate.

Elements of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category:	C
Stated Goal (%):	90
Month 1 Date:	11/2012
Month 1 Actual Goal (%):	94
Month 2 Date:	12/2012
Month 2 Actual Goal (%):	95
Month 3 Date:	01/2013
Month 3 Actual Goal (%):	98
Month 4 Date:	02/2013
Month 4 Actual Goal (%):	97
Actual Average Goal (%):	96
Optional Comments:	

HAP Standard PC.01.02.03 The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Elements of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a

procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 11/2012
Month 1 Actual Goal (%): 97
Month 2 Date: 12/2012
Month 2 Actual Goal (%): 98
Month 3 Date: 01/2013
Month 3 Actual Goal (%): 94
Month 4 Date: 02/2013
Month 4 Actual Goal (%): 94
Actual Average Goal (%): 96
Optional Comments:

HAP   Standard PC.03.05.03 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.

Elements of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 11/2012
Month 1 Actual Goal (%): 84
Month 2 Date: 12/2012
Month 2 Actual Goal (%): 100
Month 3 Date: 01/2013
Month 3 Actual Goal (%): 100
Month 4 Date: 02/2013
Month 4 Actual Goal (%): 100
Actual Average Goal (%): 96
Optional Comments:

HAP   Standard UP.01.03.01 A time-out is performed before the procedure.

Elements of Performance:

5. Document the completion of the time-out. Note: The hospital determines the amount and type of

documentation.

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 11/2012
Month 1 Actual Goal (%): 95
Month 2 Date: 12/2012
Month 2 Actual Goal (%): 98
Month 3 Date: 01/2012
Month 3 Actual Goal (%): 99
Month 4 Date: 2/2012
Month 4 Actual Goal (%): 98
Actual Average Goal (%): 97
Optional Comments:

Tab 21

Attachment C
Contribution to the Orderly Development of Health Care - 7.(c)

Hospital License

Board for Licensing Health Care Facilities

State of Tennessee

0000000116

No. of Beds 0155

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SUMNER REGIONAL MEDICAL CENTER, LLC to conduct and maintain a

Hospital SUMNER REGIONAL MEDICAL CENTER

Located at 555 HARTSVILLE PIKE, GALLATIN

County of SUMNER, Tennessee.

This license shall expire JUNE 25, 2016, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 28TH day of MAY, 2015.

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC GENERAL HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature] MD
COMMISSIONER

000406

Tab 22

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Inspection Report

RECEIVED
OCT 18 2006

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
MIDDLE TENNESSEE REGIONAL OFFICE
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37247-0530
PHONE (615) 650-7100
FAX (615) 650-7101

October 17, 2006

R. Bruce James, Administrator
Sumner Regional Medical Center
555 Hartsville Pike
Gallatin, TN 37066

Dear Mr. James:

Enclosed is the statement of deficiencies developed as a result of the state licensure survey completed on October 11, 2006 at Sumner Regional Medical Center.

Please provide us with documentation to describe how and when these deficiencies will be corrected. This information should be received in our office within ten (10) calendar days after receipt of this letter. We are requesting that you assure correction of the cited deficiencies no later than sixty (60) days from the date of the survey. A follow-up visit may be conducted, if your allegation of correction is reasonable and convincing. Failure to provide an acceptable plan of correction could result in a referral to the Board of Licensing Health Care Facilities for whatever action they deem appropriate.

In order for your Plan of Correction (PoC) to be acceptable, it should address the following:

1. How you will correct the deficiency;
2. Who will be responsible for correcting the deficiency;
3. The date the deficiency will be corrected; and
4. How you will prevent the same deficiency from happening again.

Should you have any questions, or if there is any way this office may be of assistance, please do not hesitate to call.

Sincerely,

Nina Monroe

Nina Monroe, Regional Administrator
Middle Tennessee Regional Office

Enclosure
NM/dv

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING ______ B. WING ______	10/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	1200-8-1-.04 (4) Administration (4) Whenever the rules and regulations of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A hospital which violates a required policy also violates the rule and regulation establishing the requirement. This Statute is not met as evidenced by: Based on observation interview and record review it was determined the facility failed to adhere to the provisions of the facility's policies labeled "Intravascular Devices" and "Medication Administration". The findings included: Observation of one random patient in the facilities Intensive Care Unit on 10/11/06 at 10:40 AM in room 6 revealed a Patient whom had two Intravenous Dressings. One dressing was covering a Triple Lumen Catheter that was located on the Patients right subclavian area of the anterior chest and the other Intravenous access was located in the patients right arm antecubital area. Observation of the dressings revealed there was no documentation on the transparent dressings of either site. Record review Patient #27 of 37 sampled Patients revealed documentation by the Medical Doctor on 10/10/06 at 1500 in the Physicians Progress notes indicating the Triple Lumen Catheter was placed in Patient #27 on 10/10/06. Confirmation was made with the Intensive Care Unit, Care Coordinator of these findings on 10/11/06 at 10:50 AM. The policy labeled	H 404		

Division of Health Care Facilities

'ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H 404	Continued From page 1 "Intravascular Devices" reads on page 2 of the policy "I. Documentation 1. Record date and time of catheter insertion on label provided in the IV start kit and attach to IV dressing." Tour of the facilities operating room on 10/10/06 at 11:00 AM in room 1 revealed 22 milliliters of a white liquid in a 30 milliliter syringe located on top of an anesthesia cart unattended. Further observation revealed the cart was unlocked. There was no label noted on the syringe containing the 22 milliliters of the white liquid. Interview with an anesthesiologist in the surgery hallway on 10/10/06 at 11:05 reports "We don't label the propofol." Confirmation was made with the Surgery Director on 10/10/06 at 11:06 AM that the medication should be labeled. Review of the facilities policy labeled "Medication Administration" reads under the section labeled Procedure: "12. Medications and solutions both on and off the sterile field should be labeled even if there is only one medication being used. 13. Labeling occurs when any medication or solution is transferred from the original packaging to another. 14. Labels should include drug name, strength, amount, if not used within 24 hours, and expiration time when expiration occurs in less than 24 hours." Observation on 10/10/06 at 3:15 PM during an interview with Patient # 37 of the 37 sampled Patients revealed a right Port-A-Cath central line intravenous dressing with no date and signature. The findings were confirmed in an interview with the 4th Floor charge nurse at this time. Medical record review on 10/10/06 at 3:20 PM revealed a needle and dressing change documented in the	H 404		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING ______ B. WING ______	10/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

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H 404	Continued From page 2 nursing notes at 8:45 AM on 10/10/06. The facility policy to date and initial all intravenous dressings was confirmed on 10/10/06 at 3:20 PM by the Director of Medical/Surgical and the 4th Floor charge nurse. Review of the facility policy entitled, "Intravascular Devices" revealed that documentation should include recording the date and time of the catheter insertion on the label provided in the intravenous start kit and attach to the intravenous dressing.	H 404		
H 647	1200-8-1-.06 (3)(i)4. Basic Hospital Functions (3) Infection Control. (i) The central sterile supply area(s) shall be supervised by an employee, qualified by education and/or experience with a basic knowledge of bacteriology and sterilization principles, who is responsible for developing and implementing written policies and procedures for the daily operation of the central sterile supply area, including: 4. Provisions for maintenance of package integrity and designation of event-related shelf life for hospital-sterilized and commercially prepared supplies; This Statute is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sterility and package integrity of several random items found in the facilities clinical areas that were out of date as per the manufacturer guidelines. The findings included:	H 647		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING ______ B. WING ______	10/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H 647	Continued From page 3 During tour in the Intensive Care Unit 10/11/06 at 10:55 AM in the "Line Cart" located in front of the Intensive Care Units Nursing Station revealed a package in the third drawer in the cart that contained a package labeled "Scrub Care Preoperative Skin Care Prep Tray" that had an expiration date printed on the package of June 2006. Confirmation was made with the Intensive Care Unit/ Care Coordinator at 11:00 AM that the package was out of date. Observation during a tour of the newborn nursery on 10/11/06 at 12:30 PM revealed expired supply items in the third drawer of the emergency supply cabinet: One 18 gauge Insyte Autoguard chest tube needle with an expiration date of January 2004. Three 14 gauge Insyte Autoguard chest tube needles with an expiration date of March 2005. Three 16 gauge Insyte Autoguard chest tube needles with an expiration date of January 2006. The above findings were confirmed with the Director of Women's Services and the Accreditation Coordinator on 10/11/06 at 1:00 PM. Review of the facility policy entitled, "Shelf Life of Sterile Supplies" revealed that all expiration dated packages of purchased sterile supplies must be checked and rotated weekly.	H 647		
H 665	1200-8-1-.06 (3)(o) Basic Hospital Functions (3) Infection Control. (o) The physical environment of the facility shall be maintained in a safe, clean and sanitary manner.	H 665		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531116	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 10/11/2006
NAME OF PROVIDER OR SUPPLIER: SUMNER REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 555 HARTSVILLE PIKE GALLATIN, TN 37066		

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H 665	Continued From page 4 This Statute is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a clean and sanitary physical environment The findings included: Observation on 10/10/06 at 11:10 AM during a tour of the 4th Floor (West) kitchen revealed a microwave with dried food matter on the inside of the unit. The findings were confirmed with the patient care coordinator at this time. Observation on 10/10/06 at 2:40 PM during a tour of the 4th Floor (East) kitchen revealed a microwave with dried food matter on the inside of the unit. The findings were confirmed with the patient care coordinator at this time. Continued tour of this unit at 2:45 PM revealed an empty patient room with an overbed table with dried brown and white matter on the internal compartment. The findings were confirmed with the accreditation coordinator at this time. Continued interview with the accreditation coordinator at this time also revealed that the room was cleaned and available for patient occupancy at the time of the observations. Observation on 10/11/06 at 10:00 AM during a tour of the 2nd Floor (West) kitchen revealed a microwave with dried food matter on the inside of the unit. The findings were confirmed with the patient care coordinator and the director of the 2nd floor at this time. Observation on 10/11/06 at 10:10 AM during a tour of the 2nd Floor (East) kitchen revealed a microwave with dried food matter on the inside of the unit. The findings were confirmed with the	H 665		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531116	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/11/2006
NAME OF PROVIDER OR SUPPLIER: SUMNER REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 555 HARTSVILLE PIKE GALLATIN, TN 37066		

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H 665	Continued From page 5 patient care coordinator and the director of the 2nd floor at this time. Observation on 10/11/06 at 11:50 AM during a tour of the Labor and Delivery unit kitchen revealed a microwave with dried food matter on the inside of the unit. The findings were confirmed with the patient care coordinator and the accreditation coordinator at this time. Continued observation at 11:58 AM revealed a sink in the workroom between the Labor, Delivery, and Recovery room (LDR) #1 and LDR #2 that contained a white container one-half full with a light yellow liquid. The findings were confirmed with the director of women's services at this time and that the container should have been removed after cleaning the room.	H 665		
H 706	1200-8-1-.06 (6)(a) Basic Hospital Functions (6) Pharmaceutical Services. (a) The hospital must have pharmaceutical services that meet the needs of the patients and are in accordance with the Tennessee Board of Pharmacy statutes and regulations. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Statute is not met as evidenced by: Based on observation, interview, and policy review the facility failed to provide Pharmaceutical Services in compliance with approved policies and procedures. The findings included:	H 706		

Division of Health Care Facilities

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H 706	Continued From page 6 Observation of the Preoperative Area in the Surgery Department on 10/10/06 at 10:00 AM revealed a refrigerator that contained in the side door compartment a 0.9 % saline solution 500 milliliter clear plastic bag for intravenous infusion with an expiration date that reads "June 06". Confirmation was made with the Director of Surgical Services at 10/10/06 at 10:10 AM. During tour of the Intensive Care Unit on 10/11/06 at 10:55 AM revealed a "Line Cart" located in front of the nurses desk that contained a 1 liter bottle of 0.9% saline solution with an expiration date of February 05. Further observation of the "Line Cart" revealed a 250 milliliter clear plastic bag labeled 5% Dextrose solution for intravenous infusion with an expiration date of January 05.Confirmation was made with the Intensive Care Unit/ Care Coordinator on 10/11/06 at 11:00 AM of the expired items. Review of the facility policy labeled "Outdated or Unusable Drugs (Return to Pharmacy)" Policy Number Rx-036 reads under the section labeled Procedure reads, "1. Whenever unusable or outdated drugs are found in the hospital, they will be returned to the Pharmacy for proper disposal." The facility policy labeled Out-Dated Drugs (Storage and Disposition) Policy Number Rx-037, reads "The Pharmacy stock and all drug storage areas in the hospital are checked monthly for out dated-drugs." Observation on 10/10/06 at 2:35 PM during a tour of the 4th Floor (East) unit clean supply room revealed three 5 liter bags of sterile water for irrigation with an expiration date of September 2006. The findings were confirmed in an	H 706		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H 706	Continued From page 7 interview with the medical/surgical director at this time. Continued observation of the 4th Floor medication Pyxis sytem at 2:55 PM revealed a locked medication refrigerator attached to the Pyxis that contained an opened, one-half full bottle of Citrate of Magnesia labeled Room 433B. An interview with the medical/surgical director at 3:05 PM on 10/10/06 revealed that the Patient had been discharged on 8/31/06. Observation on 10/11/06 at 11:40 AM during a tour of the postpartum unit clean supply room revealed the following expired drugs: One liter bag of Dextrose 5% in Water with an expiration date of September 2006. One liter bag of Dextrose 5% in 0.2% Sodium Chloride solution with an expiration date of September 2006. The above findings were confirmed in an interview with the director of women's services at this time.	H 706		
H 714	1200-8-1-.06 (7)(a) Basic Hospital Functions (7) Radiologic Services. (a) The hospital must maintain, or have available, diagnostic radiologic services according to the needs of the patients. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications. This Statute is not met as evidenced by: Based on observations, interviews, and policy review the facility failed to ensure the safety of	H 714		

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H 714	Continued From page 8 one radiology employee. The findings included: Observations of the Radiology Department on October 11, 2006, revealed a Registered Nurse (RN#1) working in the Computed Tomography Room at 10:00 am, and in the Nuclear Medicine Room at 10:10 am, without a dose/film badge on his/her person. Interview with RN#1, at 10:00 am, on October 11, 2006, revealed the RN worked as a contract employee in Interventional Radiology, and had been employed at the facility for seven weeks. Interview with the Radiology Department Manager at 10:00 am, on October 11, 2006, confirmed RN#1 should have been wearing a dose/film badge. Review of the facility's Radiation Safety Operations Manual revealed all employees requiring dosimetry shall be issued a standard film badge and/or thermoluminescent dosimeter, and the exposure measurements will be recorded and kept on file.	H 714		
H 730	1200-8-1-.06 (9)(b) Basic Hospital Functions (9) Food and Dietetic Services. (b) The hospital must designate a person to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be: 1. A dietitian; or, 2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or,	H 730		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H 730	Continued From page 9 3. A graduate of a state-approved course that provided ninety (90) or more hours of classroom instruction in food service supervision and has experience as a food service supervisor in a health care institution with consultation from a qualified dietitian. This Statute Is not met as evidenced by: Based on review of employee records and staff interview, it was determined the facility failed to have a qualified food service director. The findings included: Review of the record for the Food Service Director revealed and interview, with this Employee the afternoon of 10/10/06, confirmed, the Employee was not enrolled in or had attended a 90 + hour food service supervision course.	H 730		
H 737	1200-8-1-.06 (9)(g) Basic Hospital Functions (9) Food and Dietetic Services. (g) A minimum of three (3) meals in each twenty-four (24) hour period shall be served. A supplemental night meal shall be served if more than fourteen (14) hours lapse between supper and breakfast. Additional nourishment shall be provided to patients with special dietary needs. This Statute Is not met as evidenced by: Based on staff interviews, it was determined the facility exceeded the 14 hour lapse between supper and breakfast and did not provide a supplemental meal. The findings included:	H 737		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 737	Continued From page 10 Interview with the facility Food Service Director and shift manager, the morning of 10/10/06, confirmed the Supper was served at 4:15 PM and the Breakfast at 7 AM without a supplemental meal between those hours to the patients.	H 737		
H 739	1200-8-1-.06 (9)(i) Basic Hospital Functions (9) Food and Dietetic Services. (i) Food shall be protected from sources of contamination whether in storage or while being prepared, served and/or transported. Perishable foods shall be stored at such temperatures as to prevent spoilage. Potentially hazardous foods shall be maintained at safe temperatures as defined in the current "U.S. Public Health Service Food Service Sanitation Manual". This Statute is not met as evidenced by: Based on observation and staff interview, it was determined the dietary department was not maintained in a sanitary manner and cold food exceeded 41 degrees at the trayline. the findings included: Observation during the department tour, at 9:15 AM of 10/10/06, with the Food Service Director present, revealed the following ceiling vents and surrounding ceiling tiles had an accumulation of debris: between the grill and steamer; over the production table and steam jacketed kettle; in the dishroom on the dirty side, clean side and over the 3 compartment sink; by the reach-in refrigerators between the production and catering	H 739		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING ______ B. WING ______	10/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 739	Continued From page 11 sections and outside the diet office. Observation at 9:38 AM revealed the dishes were being processed and the 3 compartment sink was being used in the dishroom. Further observation during the tour revealed four cases of cups were stacked and a case of cup lids were stored on the floor of the paper storeroom. Observation during the mid-day meal trayline revealed a staff member taking and recording the food temperatures at 11:30 AM. Continued observation revealed the milk temperature was 43 degrees and served to the pureed textured diets. Interview, at 11:40 AM, with the shift manager revealed the person taking the temperatures was instructed to remove and replace any foods not in the appropriate temperature ranges.	H 739		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING ______ B. WING ______	10/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 001	1200-8-30 Initial This Statute is met as evidenced by: No deficiencies were cited as a result of the Pediatric Emergency Care Facility Survey completed on October 11, 2006.	P 001		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING 02 - STATE BUILDING B. WING	10/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 872	1200-8-1-.08 (2) Building Standards (2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to maintain the hospital environment for the safety of both residents and staff as required by the Standard Regulation 1200-8-1-08(2) the NFPA 101, 8.5.5.2; 101, 8.5.5.3. The findings included: On 10-10-2006 at approximately 2:00 PM during inspection within the basement equipment room, observation revealed, there were penetrations in both the ceiling and the wall.	H 872		
H 874	1200-8-1-.08 (4) Building Standards. (4) After the application and licensure fees have been submitted, the building construction plans must be submitted to the department. All new facilities shall conform to the current addition of the Standard Building Code, the National Fire Protection Code (NFPA), the National Electrical Code, the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities, and the U.S Public Health Service Food Code as adopted by the Board for Licensing Health Care Facilities. When referring to height, area or construction type, the Standard Building Code shall prevail. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.). Where there are	H 874		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING 02 - STATE BUILDING B. WING ______	10/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 874	Continued From page 1 conflicts between requirements in the above listed codes and regulations and provisions of this chapter, the most restrictive shall apply. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to comply with the Regulatory Codes as required by the Standard Regulation 1200-8-1-08(4) and the Standard Building Code- SBC 1403.2.3. The findings included: On 10-10-2006 at approximately 1:45 PM during inspection within the basement area, observation revealed, a steel lintel carrying brick veneer over a doorway was missing. SBC 1403.2.3.	H 874		
H 893	1200-8-1-.08 (23) Building Standards. (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection, testing and observation, it was determined, the facility failed to maintain the negative air pressure within soiled areas as required by the Standard Regulation 1200-8-1-08(23) and the NFPA 90A; 90B-4; 101, 19. 5.2.1.	H 893		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531116	A. BUILDING 02 - STATE BUILDING B. WING ______	10/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 893	Continued From page 2 The findings included: On 10-10-2006 at approximately 2:30 PM during inspection within the men's bathroom in the Cath Lab area, testing revealed, the exhaust fan units were not working. Inspection and observation within the Medical Imaging area revealed, the return-air grilles were dusty. Inspection and observation within the elevator equipment room revealed, the exhaust fan unit was dusty. During inspection and observation within the dietary area, observation revealed, both air-return units and exhaust fan grilles were dusty.	H 893		
H 951	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 16862 Based on inspection and observation, it was determined, the facility failed to comply with the applicable building and fire safety regulations as required by the Standard Regulation 1200-8-1-08(1). and the NFPA 10, 1.5.6; 55, 6.6; 70, 240-5; 70, 373-4; 410-56(d).	H 951		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531116	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - STATE BUILDING B. WING ______	(X3) DATE SURVEY COMPLETED 10/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMNER REGIONAL MEDICAL CENTER	555 HARTSVILLE PIKE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 951	Continued From page 3 The findings included: On 10-10-2006 at approximately 12:30 PM during inspection within the basement shop area, observation revealed, the portable fire extinguisher was blocked with equipment. That was in violation of the NFPA 10, 1.5.6. Inspection within the storage area of the basement mechanical room revealed three pressurized cylinders which were not secured. Violation of the NFPA 55, 6.6. During inspection within the pain clinic of the Cath Lab area, observation revealed the use of an extension cord. NFPA 70, 240-5. During inspection on the 3rd floor next to the rehab area, observation within the electric panel room revealed, panels TA and TB both had unusual open space under the breakers. Violation of the NFPA 70, 373-4. During inspection within the basement mechanical equipment area, observation revealed a junction box without any cover plate. During inspection within the ceiling space above the east fire doors to the Cath Lab area, observation revealed, there was an open junction box without any cover plate. Inspection above the west fire doors of the Cath Lab revealed open junction box with loose wires. Those were in violation of the NFPA 70, 410-56(d).	H 951		

Tab 23

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Plan of Corrective Action

SUMNER
Regional Medical Center

Administrative Offices

October 24, 2006

Ms. Nina Monroe, Regional Administrator
State of Tennessee Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, Tennessee 37247-0530

Dear Ms. Monroe:

The following information is provided in response to the recent state licensure survey completed on October 11, 2006 at Sumner Regional Medical Center.

ID Prefix Tag: H 404 1200-8-.04 (4) Administration

How SRMC will correct the deficiency: We will correct "no documentation on the transparent intravenous dressing" by following our policy and recording date and time of catheter insertion on the label provided in the IV starter kit and then attaching it to the IV dressing.
Who at SRMC will be responsible for correcting the deficiency: Director, Med/Surg
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted in all patient care areas specifically looking for this documentation.

How SRMC will correct the deficiency: We will correct failure to label medication and solutions both on and off the sterile field by following our stated policy and further educating our staff and anesthesiologists.
Who at SRMC will be responsible for correcting the deficiency: Director, Surgical Services, and Director Women's Services
The date the deficiency will be corrected: November 1, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted to ensure compliance with re-education as needed.

Post Office Box 1558 555 Hartsville Pike Gallatin, Tennessee 37066-1588 (615) 451-5519 FAX (615) 451-5523

How SRMC will correct the deficiency: We will ensure that all anesthesia carts are locked when not in use.
Who at SRMC will be responsible for correcting the deficiency: Director, Surgical Services, and Director Women's Services
The date the deficiency will be corrected: November 1, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted to ensure compliance with re-education as needed.

How SRMC will correct the deficiency: We will correct "no documentation on the transparent intravenous dressing of Port-A-Cath" by following our policy and recording date and time of catheter insertion on the label provided in the IV starter kit and then attaching it to the IV dressing.
Who at SRMC will be responsible for correcting the deficiency: Director, Med/Surg
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted in all patient care areas specifically looking for this documentation.

ID Prefix Tag: H 647 1200-8-1-.06 (3)(i) 4 Basic Hospital Function

How SRMC will correct the deficiency: We will re-educate stocking personnel on the importance of accuracy of daily checks and ensuring that no items remain in stock after expiration date.
Who at SRMC will be responsible for correcting the deficiency: Director, Material Management
The date the deficiency will be corrected: November 1, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted in all patient care areas specifically looking at expiration dates to ensure compliance and immediate re-education as required.

ID Prefix Tag: H 665 1200-8-1-.06 (3)(o) Basic Hospital Functions

How SRMC will correct the deficiency: We will immediately correct and reeducate environmental services associates on proper cleaning of microwave ovens and bed side tables, and disposal of used cleaning materials.
Who at SRMC will be responsible for correcting the deficiency: Director, Environmental Services
The date the deficiency will be corrected: October 11, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted in all patient care areas specifically ensuring these deficiencies remain in compliance.

ID Prefix Tag: H 706 1200-8-1-.06 (6)(a) Basic Hospital Functions

How SRMC will correct the deficiency: We will immediately check all supply carts to ensure no expired solutions remain.
Who at SRMC will be responsible for correcting the deficiency: Director, Material Management
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted in all patient care areas specifically ensuring that expired items do not exist.

How SRMC will correct the deficiency: We will ensure that all medications belonging to a specific patient are removed when that patient leaves the hospital.
Who at SRMC will be responsible for correcting the deficiency: Director, Pharmacy
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Pyxis units are checked daily by Pharmacy staff. They will ensure this occurs. Spot checks will be conducted on all Pyxis units specifically ensuring that expired items or medications from previous patients do not exist.

ID Prefix Tag: H 714 1200-8-1-.06 (7)(a) Basic Hospital Functions

How SRMC will correct the deficiency: We will make sure that all Radiology Department associates wear a dose/film badge.
Who at SRMC will be responsible for correcting the deficiency: Director, Diagnostic Services
The date the deficiency will be corrected: October 11, 2006
How will SRMC prevent the same deficiency from happening again: Spot checks will be conducted in all diagnostic imagining areas specifically ensuring dose/film badges are worn by all associates working in that area.

ID Prefix Tag: H 730 1200-8-1-.06 (9)(b) Basic Hospital Functions

How SRMC will correct the deficiency: We will enroll the Director, Nutritional Service in a 90 hour food service supervisor course and make sure that he completes the course within two years.
Who at SRMC will be responsible for correcting the deficiency: Vice President, Support Services
The date the deficiency will be corrected: No later than October 11, 2008.
How will SRMC prevent the same deficiency from happening again: Vice President, Support Services will ensure that this requirement is added to the current contract as well as any future contracts and then annually reviewed for compliance.

ID Prefix Tag: H 737 1200-8-1-.06 (9)(g) Basic Hospital Functions

How SRMC will correct the deficiency: We will ensure that no more than 14 hours lapse between supper and breakfast.
Who at SRMC will be responsible for correcting the deficiency: Director, Nutritional Services
The date the deficiency will be corrected: November 20, 2006
How will SRMC prevent the same deficiency from happening again: By adjusting meal service hours on the inpatient floors, not exceeding 14 hours becomes the standard. Spot checks will monitor compliance.

ID Prefix Tag: H 739 1200-8-1-.06 (9)(i) Basic Hospital Functions

How SRMC will correct the deficiency: We will immediately clean and maintain cleanliness in all areas sited.
Who at SRMC will be responsible for correcting the deficiency: Director, Nutritional Services
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Daily inspections and spot checks. Note: State surveyor re-examined area on October 12, 2006 and verbally expressed her satisfaction with the previous night's cleaning.

How SRMC will correct the deficiency: Closer monitoring of the cold food temperatures in the tray line and meal preparation areas.
Who at SRMC will be responsible for correcting the deficiency: Director, Nutritional Services
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Daily inspections and spot checks.

ID Prefix Tag: H 872 1200-8-1-.08 (2) Building Standards

How SRMC will correct the deficiency: We will seal all penetrations in the wall and ceiling in the basement equipment room.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: November 30, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations as well as the Director, Safety and Security. Spot checks as part of the Environment of Care (JCAHO) continuous readiness.

ID Prefix Tag: H 874 1200-8-1-.08 (4) Building Standards

How SRMC will correct the deficiency: We will install a steel lintel carrying brick veneer over a doorway in the basement area.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: November 30, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations as well as the Director, Safety and Security. Spot checks as part of the Environment of Care (JCAHO) continuous readiness.

ID Prefix Tag: H 893 1200-8-1.08 (23) Building Standards

How SRMC will correct the deficiency: We will repair and clean exhaust fans in the Cath Lab, Medical Imaging, Elevator Equipment room and Dietary areas.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations, Director, Environmental Services, Director Nutritional Services
The date the deficiency will be corrected: October 20, 2006
How will SRMC prevent the same deficiency from happening again: Increased inspections and spot checks by appropriate Director.

ID Prefix Tag: H 951 1200-8-1-.09 (1) Life Safety

How SRMC will correct the deficiency: We will ensure that all portable fire extinguishers are readily available and not blocked from use.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

How SRMC will correct the deficiency: We will ensure that all pressurized cylinders are properly secured.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: October 12, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

How SRMC will correct the deficiency: We will remove the extension cord in the Cath Lab and ensure that appropriate electrical outlets are available.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: November 30, 2006

How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

How SRMC will correct the deficiency: We will secure the open space under the breakers in electrical panel 3rd Floor, TA and TB.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: October 20, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

How SRMC will correct the deficiency: We will cover the junction box in the basement mechanical equipment area.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: October 20, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

How SRMC will correct the deficiency: We will cover the junction box in the ceiling space above the east fire doors to the Cath Lab.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: October 20, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

How SRMC will correct the deficiency: We will secure the loose wires and cover the junction box above the west fire doors of the Cath Lab.
Who at SRMC will be responsible for correcting the deficiency: Director, Plant Operations
The date the deficiency will be corrected: October 20, 2006
How will SRMC prevent the same deficiency from happening again: Inspections by the Director, Plant Operations, and Director, Safety and Security.

Should you have any questions please contact Mr. Fred Levoy at 615 451-5529 or email; Fred.Levoy@Sumner.Org.

Sincerely,

R. Bruce James

R. Bruce James
Administrator

Attachment D

Copy of Published Public Notice
Letter of Intent

Tab 24

Attachment D

Copy of Published Public Notice

THE TENNESSEAN
Middle Tennessee's Marketplace for buyers, sellers and job seekers.

cy no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at, or prior to, the consideration of the application by the Agency.

Public Notices

Public Notices

0000641094

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center Emergency Department at Mt. Juliet (a proposed satellite emergency department of TriStar Summit Medical Center, a hospital), to be owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to establish a satellite emergency department facility at an unaddressed site in Wilson County, in the southwest quadrant of the intersection of I-40 and Beckwith Road (near Exit 229). The site is approximately 100 yards west of Beckwith Road on an access drive at Smyrna Ready Mix, whose address is 4910 Beckwith Road. The project cost is estimated at $11,107,000.

The proposed satellite facility will contain eight treatment rooms. It will provide emergency diagnostic and treatment services, for which all necessary diagnostic services will be available, including laboratory, X-ray, ultrasound, and CT scanning. It will not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements. The facility will be operated under TriStar Summit Medical Center's 196-bed acute care hospital license, granted by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is on or before August 14, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency

Public Notices

Public Notices

0000645174

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Sumner Regional Medical Center ("SRMC"), an existing acute care hospital, owned by Sumner Regional Medical Center, LLC with an ownership type of limited liability company and to be managed by SRMC intends to file an application for a Certificate of Need for a full service, 24-hour-per-day/7-day-per-week satellite emergency department for patients who require care on an emergency basis. The project will be located at SRMC's existing outpatient facility known as Sumner Station, 225 Big Station Camp Boulevard, Gallatin, Sumner County, TN 37066. The project will be a satellite of the main emergency department at SRMC and will be under the sole administrative control of SRMC. It involves the renovation of 10,210 square feet of existing space. The total project costs are estimated to be $5,603,276.

Sumner Regional Medical Center is licensed by the Board for Licensing Healthcare Facilities as a 155-bed acute care hospital. The proposed satellite emergency department will provide the same full emergency diagnostic and treatment services as at the main hospital, utilizing the imaging center already located at Sumner Station for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements.

The anticipated date of filing the application is: August 14, 2015. The contact person for this project is Michael Herman, Chief Operating Officer, who may be reached at Sumner Regional Medical Center, 225 Big Station Camp Boulevard, Gallatin, Tennessee, 37066, 615-328-6695.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

**Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243**

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

1. Stripping and Waxing at Parthenon Towers
2. Stripping and Waxing Edgefield Manor
3. Janitorial Services at Rental Assistance Office
4. Janitorial Services at Vine Hill Community Center Building
5. Glass Replacement Services

Copies of these bid documents may be obtained at MDHA Construction Office, 712 South Sixth Street, Nashville, TN 37206 or by contacting Rita James at (615) 252-8432.

0000639941

SUBSTITUTE TRUSTEE'S NOTICE OF FORECLOSURE SALE

Default having been made in the terms, conditions, and payments provided in a certain Deed of Trust dated NOVEMBER 29, 2006, executed by JOHN LANKFORD SINGLE MAN, to GARY FISHER, Trustee, of record in RECORD BOOK 691 PAGE 3230 AND RE-RECORDED IN RECORD BOOK 695 PAGE 2249, for the benefit of MORTGAGE ELECTRONIC REGISTRATION SYSTEMS, INC. AS NOMINEE FOR PROFESSIONAL MORTGAGE GROUP, INC., in the Register's Office for RUTHERFORD County, Tennessee and to J. PHILLIP JONES AND/OR JESSICA D. BINKLEY, either of whom may act, appointed as Substitute Trustee in an instrument of record in the Register's Office for RUTHERFORD County, Tennessee, to secure the indebtedness described;
WHEREAS, said Deed of Trust was last assigned to TENNESSEE HOUSING DEVELOPMENT AGENCY, the entire indebtedness having been declared due and payable by TENNESSEE HOUSING DEVELOPMENT AGENCY BY AND THROUGH ITS SERVICER AND AUTHORIZED AGENT, U.S. BANK

Continued to next column

PROPERTY IS WITHOUT WARRANTY OF ANY KIND, AND IS FURTHER SUBJECT TO THE RIGHT OF ANY TENANT(S) OR OTHER PARTIES OR ENTITIES IN POSSESSION OF THE PROPERTY. ANY REPRESENTATION CONCERNING ANY ASPECT OF THE SUBJECT PROPERTY BY A THIRD PARTY IS NOT THE REPRESENTATION/ RESPONSIBILITY OF TRUSTEE(S)/ SUBSTITUTE TRUSTEE(S) OR THEIR OFFICE.
THIS SALE IS SUBJECT TO ANY UNPAID TAXES, IF ANY, ANY PRIOR LIENS OR ENCUMBRANCES LEASES, EASEMENTS AND ALL OTHER MATTERS WHICH TAKE PRIORITY OVER THE DEED OF TRUST UNDER WHICH THIS FORECLOSURE SALE IS CONDUCTED, INCLUDING BUT NOT LIMITED TO THE PRIORITY OF ANY FIXTURE FILING. IF THE U.S. DEPARTMENT OF THE TREASURY/ INTERNAL REVENUE SERVICE, THE STATE OF TENNESSEE DEPARTMENT OF REVENUE, OR THE STATE OF TENNESSEE DEPARTMENT OF LABOR AND WORK FORCE DEVELOPMENT ARE LISTED AS INTERESTED PARTIES IN THE ADVERTISEMENT, THEN THE NOTICE OF THIS FORECLOSURE IS BEING GIVEN TO THEM, AND THE SALE WILL BE SUBJECT TO THE APPLICABLE GOVERNMENTAL ENTITIES RIGHT TO REDEEM THE PROPERTY, ALL AS REQUIRED BY 26 U.S.C. 7425 AND T.C.A. 67-1-1433. THE NOTICE REQUIREMENTS OF T.C.A. 35-5-101 ET SEQ. HAVE BEEN MET.
THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FUR-

Continued to next column

Tab 25

Attachment D

Letter of Intent

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Sumner (County), Tennessee, on or before August 10 (Month / day), 20 15 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Sumner Regional Medical Center ("SRMC") (Name of Applicant) — an existing acute care hospital (Facility Type-Existing)

owned by: Sumner Regional Medical Center, LLC with an ownership type of Limited Liability Company

and to be managed by: SRMC intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: a full service, 24-hour-per-day/7-day-per-week satellite emergency department for patients who require care on an emergency basis. The project will be located at SRMC's existing outpatient facility known as Sumner Station, 225 Big Station Camp Boulevard, Gallatin, Sumner County, TN 37066. The project will be a satellite of the main emergency department at SRMC and will be under the sole administrative control of SRMC. It involves the renovation of 10,210 square feet of existing space. The total project costs are estimated to be $5,603,276.

Sumner Regional Medical Center is licensed by the Board for Licensing Healthcare Facilities as a 155-bed acute care hospital. The proposed satellite emergency department will provide the same full emergency diagnostic and treatment services as at the main hospital, utilizing the imaging center already located at Sumner Station for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements.

The anticipated date of filing the application is: August 14, 20 15

The contact person for this project is Michael Herman (Contact Name) Chief Operating Officer (Title)

who may be reached at: Sumner Regional Medical Center (Company Name) 225 Big Station Camp Boulevard (Address)

Gallatin (City) TN (State) 37066 (Zip Code) 615 / 328-6695 (Area Code / Phone Number)

[signature] (Signature) 8-7-15 (Date) Michael.Herman@LPNT.net (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

September 1, 2015

Michael Herman
Sumner Regional Medical Center
555 Hartsville Pike
Gallatin, TN 37066

RE: Certificate of Need Application -- Sumner Regional Medical Center Satellite ED – CN1508-029
To establish a full service, 24 hour per day/7 day per week satellite emergency department. The proposed satellite emergency department is planned to be located at Sumer Regional Medical Center's existing outpatient facility known as Sumner Station located at 225 Big Station Camp Boulevard, Gallatin (Sumner County), TN 37066. The estimated project cost is $7,081,754.

Dear Mr. Herman:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on September 1, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on November 18, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: September 1, 2015

RE: Certificate of Need Application
Sumner Regional Medical Center Satellite ED - CN1508-029

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on September 1, 2015 and end on November 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Michael Herman

AUG 10 '15 AM10:05

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Sumner (County), Tennessee, on or before August 10 (Month / day), 2015 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.,* and the Rules of the Health Services and Development Agency, that:

Sumner Regional Medical Center ("SRMC") (Name of Applicant), an existing acute care hospital (Facility Type-Existing)

owned by: Sumner Regional Medical Center, LLC with an ownership type of Limited Liability Company

and to be managed by: SRMC intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: a full service, 24-hour-per-day/7-day-per-week satellite emergency department for patients who require care on an emergency basis. The project will be located at SRMC's existing outpatient facility known as Sumner Station, 225 Big Station Camp Boulevard, Gallatin, Sumner County, TN 37066. The project will be a satellite of the main emergency department at SRMC and will be under the sole administrative control of SRMC. It involves the renovation of 10,210 square feet of existing space. The total project costs are estimated to be $5,603,276.

Sumner Regional Medical Center is licensed by the Board for Licensing Healthcare Facilities as a 155-bed acute care hospital. The proposed satellite emergency department will provide the same full emergency diagnostic and treatment services as at the main hospital, utilizing the imaging center already located at Sumner Station for diagnostic services such as CT and MRI. The project does not contain major medical equipment, or initiate or discontinue any other health service, or affect any facility's licensed bed complements.

The anticipated date of filing the application is: August 14, 2015

The contact person for this project is Michael Herman (Contact Name) Chief Operating Officer (Title)

who may be reached at: Sumner Regional Medical Center (Company Name) 225 Big Station Camp Boulevard (Address)

Gallatin (City) TN (State) 37066 (Zip Code) 615 / 328-6695 (Area Code / Phone Number)

[signature] (Signature) 8-7-15 (Date) Michael.Herman@LPNT.net (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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Supplemental #1
-Original-

Sumner Regional Medical Center

CN1508-029

SUPPLEMENTAL #1
August 25, 2015
2:15 pm

August 25, 2015

Via Hand Delivery

Mr. Phillip Earhart
Health Services Development Examiner
Health Services Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

RE: Certificate of Need Application CN1508-029
Sumner Regional Medical Center (Satellite Emergency Department)

Dear Mr. Earhart:

Thank you for acknowledging receipt of our August 14, 2015 application for a Certificate of Need to establish a full service, 24 hour per day/7 day per week satellite emergency department to be located at 225 Big Station Camp Boulevard, Gallatin (Sumner County), Tennessee 37066.

We received your request for supplemental information on August 18th. **Our responses, below, are provided in triplicate by the deadline of 4PM, Tuesday August 25, 2015.**

---

1. **Section B, Project Description, Item I.**

   What is the average wait time in the applicant's current main emergency department?

   Response: The average wait time at Sumner Regional Medical Center's ("SRMC") emergency department ("ED") is 16 minutes[1], measured from the time the patient enters the ED to the time their medical screening exam begins.

   Please provide an overview of the applicant's experience in operating a satellite emergency facility.

   Response: Highpoint Health System (the hospital system of which SRMC is the flagship hospital) operates three successful emergency departments in Middle Tennessee that provided more than 57,000 visits in 2013[2]. Emergency medicine requires the same resources and expertise, regardless of its location and adjacency to full-service hospitals. The applicant expects no change in the level of service and care for its patients in its satellite emergency department.

---

[1] Year to date, 2015
[2] Tennessee Joint Annual Reports

What are the main factors that prevent the applicant from requesting a CON for expanding the main hospital campus by adding the 5 rooms being requested for the proposed satellite ED?

Response: As discussed in the main application, SRMC added three additional ED patient treatment rooms in 2014. This moderate expansion was accomplished inexpensively through the conversion of existing office space. Unfortunately, there is no longer any additional "soft" space available for conversion to clinical use. SRMC has thoroughly maximized the footprint of its current ED service, and there is simply no internal/adjacent expansion capacity remaining.

SRMC's main campus ED is located in a walk-in type basement level of the main hospital.

- It is impractical and cost prohibitive to tunnel into subterranean areas below the existing property grade.
- Portions of the outer walls of the ED space border on adjacent property not owned by SRMC.
- The remaining outer walls (the "walk-in" portions) open to the ED patient entrance and ambulance entrance/parking area. These entrances cannot be moved and the parking cannot be reduced.
- Though the ED is adjacent to radiology, relocating radiology to new construction would prove extremely expensive due to the highly fixed nature of the service's equipment and special shielding, electrical and cooling requirements. Furthermore, radiology relocation would result in transport and screening delays for all inpatients and outpatients.

Due to these facility constraints, SRMC's only ED expansion option is to add newly constructed space. For this option, Sumner Station was deemed more appropriate than the main campus.

Please clarify if mobile crisis staff will have access to conduct assessments. If so, where? Where will law enforcement be located?

Response: Yes, mobile crisis staff will have access to conduct an assessment in the patient care area and/or the patient treatment room. If law enforcement agencies are accompanying a patient or needs to interact with the patient, accommodations will be made in the patient care area and/or treatment room.

Many times emergency room copays are waived if the patient is admitted inpatient. Please clarify if this arrangement is possible at the proposed satellite ED.

Response: Yes, such arrangements are possible and will be implemented at the satellite ED. The SRMC Satellite ED will be licensed and operated as part of Sumner Regional Medical Center. All hospital-based billing arrangements, including co-pays and indigent/charity care policies, are applicable to the satellite ED.

Please clarify if an ambulance will be stationed at the satellite ED 24 hours/day, 7days/week, 365 days/year for life-threatening transports to full service hospitals. In your response, please also identify locations of emergency ambulance locations in the proposed zip code service area.

Response: A Sumner County fire station with a dedicated EMS ambulance is located within a mile of the Sumner Station facility. This ambulance is ready to respond to emergency situations at Sumner Station and to expedite urgent and emergent transfers to full-service hospitals.

In fact, the Sumner County EMS operates 12 of these advanced life support (ALS) emergency ambulance units in Sumner County, with each unit carrying at least one licensed Paramedic.

Please see the table below for the location and count of these ALS ambulance units.

Location	# of ALS Units
Gallatin	2
Station Camp	1
Hendersonville	3
Portland	2
Westmoreland	1
Oak Grove	1
Castallian Springs	1
White House	1

Source: Sumner EMS

It is noted the applicant will provide 24/7 imaging services to the proposed satellite emergency department. Please clarify if the cost of operating the existing imaging center on weekends and after hours will be charged to the proposed emergency department. In addition, please clarify which imaging equipment would be used by the emergency department.

Response: Consistent with SRMC's current existing department cost allocation policies, no additional imaging costs will be allocated to the satellite ED. The satellite ED will have access to all imaging equipment required for emergent conditions, including CT, MRI, x-ray and ultrasound. A CT tech will be available on-site at the facility on a 24/7 basis. When the MRI tech is not on-site during normal weekday hours, one will be on call.

Please discuss if the role of telemedicine in the emergency department and the possibilities of using an off-site physician to examine ER patients during overcrowding. Please include in your response if the new proposed satellite ER will have telemedicine capabilities. If so, what will the capabilities be?

Response: The satellite ED will have access to the same level of telemedicine services now provided at the main ED.

- For primarily stroke and trauma patients, SRMC currently has a tele-neurology contract in place with Vanderbilt's neurology physicians, all of whom are credentialed on SRMC's medical staff.
- Similarly, tele-cardiology will allow STEMI patients to by-pass the main ED and go straight to SRMC's cath lab for emergent treatment.

What types of innovative programs have been implemented by the applicant to ease emergency department overcrowding?

Response: To ease ED overcrowding, SRMC has utilized Lean Six Sigma black belts to examine and improve processes. This has reduced wait times and improved patient throughput. SRMC carefully balances resources to ensure that staff is available at peak times. Staffing schedules are frequently reassessed and adjusted to ensure that the total times patients spend at the ED are appropriate.

In December 2014, Tennessee Gov. Bill Haslam unveiled his Insure Tennessee plan, a two year pilot program to provide health care coverage to Tennesseans who currently don't have access to health insurance or have limited options. The program rewards healthy behaviors, prepares members to transition to private coverage, promotes personal responsibility and incentivizes choosing preventative and routine care instead of unnecessary use of emergency rooms. If passed, what will the impact of Insure TN have on the applicant's volume projection?

Response: Based on information available so far, the Insure Tennessee plan is expected to have a minimal impact on SRMC's Satellite ER volume projections.

- SRMC's services and facilities are offered to all patients in need of care, regardless of payor source.
- It is widely accepted that uninsured populations are underserved because they pursue as little healthcare as possible due to high costs.
- Lawmakers in Nashville voted down Governor Bill Haslam's Insure Tennessee plan twice, first in a special legislative session in February 2015 and then in the Senate Commerce and Labor Committee in March 2015.

Plans to extend medical coverage to 280,000 Tennesseans have failed. This population remains largely dependent on emergency departments for their care.

2. **Section C, Project Description, Item II.A**

The square footage and cost per square footage chart is noted. However, please clarify how the mechanical/electrical and circulation/structure GSF is included in the 10,210 SF renovation.

Response: Yes, the mechanical/electrical and circulation/structure GSF is included in the 10,210 SF renovation costs and cost per square foot listed in the original application. At less than 300 SF for these functions, the space had no material impact on overall cost per square foot.

Please clarify if the 735 SF for future use is included in the 10,210 SF renovation.

Response: Yes, the 735 SF of shelled space for future use is included in the 10,210 SF renovation. SRMC proposes to occupy space at Sumner Station currently used as an indoor basketball court. While the vast majority (93%) of the space in this existing footprint can be used by the satellite ED, a use for the final 735 SF (7%) has not yet been identified.

3. **Section B, Project Description, Item III.A and**
The plot plan for the proposed facility on a 24.57 acre site is noted. Please indicate the future plans the applicant has for the remaining parcel of land.

Response: The applicant does not currently have any future plans for the remaining parcel of land.

Please clarify the reason a helipad is not included in the plot plan.

Response: The proposed satellite ED will not have a helipad provided. A helipad is not required for licensure, and this was clarified with the State of Tennessee Department of Health prior to application. However, the project will have 24/7 EMS ground ambulance service at a fire station less than one mile away for expedited transport of acute care patients.

4. **Section B, Project Description, Item IV (Floor Plan)**

The floor plan of the proposed satellite facility is noted. Please provide clarification for the following:

- 735 square feet of future space is noted. Please indicate the future plans for the space.

  Response: SRMC proposes to occupy space at Sumner Station currently used as an indoor basketball court. The 735 SF of future space is included in the footprint of the building as it exists today. While the vast majority (93%) of the space in this existing footprint can be used by the satellite ED, a use for the final 735 SF (7%) has not yet been identified. If it were not shelled out as a part of this project, the space would remain available, but completely unutilized. The 735 square feet of shelled space is available for future expansion as demand dictates. However, SRMC has no current plans to do so.

- The floor plans indicate there is an elevator and stairs. Please describe the building the proposed service will be located and the services included.

  Response: The proposed satellite ED will be located at the Sumner Station outpatient facility, in a space that is two stories high and currently used as a basketball court. The ED will be located on the first floor. Renovations to the space to create the ED will also create additional rentable space above the ED, ultimately envisioned to contain two medical office suites. Life safety code requirements dictate the need for the additional third elevator and third stairs reflected in the floor plans.

  Please note that the applicant has not reflected any potential rental revenues on these two office suites in its pro formas, and that all renovation costs involved were included in the original CON application.

  Other space within the building is currently occupied by a diagnostic imaging center, an OT/PT/Speech practice, a Pediatrics practice, a Family Practice office and a Sports Medicine practice. The Radiation Oncology and Medical Oncology programs are in the process of relocating from the main hospital to Sumner Station[3].

- Please describe if there will be a behavior room. If so, how will the room be secured?

  Response: Yes, there will be a behavior room. As in SRMC's main ED, the satellite ED will be secured by patient safety panels that will slide over medical gas lines and other potential patient hazards.

- Please indicate where the proposed future 5th treatment room will be located.

  Response: SRMC will reconfigure an adjacent 135 SF office, which will inexpensively optimize the current space and maintain patient flow.

- If needed, how may the applicant expand the proposed site to accommodate additional treatment rooms? In your response, please indicate the square footage and the number of treatment rooms.

  Response: If necessary in the future, SRMC can add four additional treatment rooms at the satellite ED by building out the 735 SF shelled space indicated for future expansion on the floor plan.

- If the applicant plans to use the existing imaging center, please clarify the reason there is a portable x-ray included in the proposed floor plan.

  Response: SRMC does plan to use the imaging center for any emergent conditions requiring its services. However, to remain consistent with the clinical practices of the hospital's main ED, an additional portable x-ray is included immediately adjacent to the patient treatment rooms.

[3] Recently approved in separate CON applications.

SUPPLEMENTAL #1

August 25, 2015
2:15 pm

- Please compare the square footage of the proposed treatment and trauma emergency department rooms with existing minimum square footage standards.

  Response: As stated in Tab 11 of the attachments included with the original application (the architect's cost verification letter), the square footage of the proposed treatment and trauma emergency department rooms have been designed in accordance with the 2010 FGI Guidelines for the Design and Construction of Health Care Facilities.

Please complete the following chart:

Proposed Changes in Emergency Department (ED)

Patient Care Areas other than Ancillary Services	# Hospital ED	# Satellite ED	# Combined EDs
Exam/Treatment Rooms	26	4	30
Multipurpose	26	4	30
Gynecological	26	4	30
Holding/Secure/Psychiatric	2	1	3
Isolation	2	1	3
Orthopedic	26	4	30
Trauma	4	1	5
Other	3		3
Triage Stations	1	1	2
Decontamination Rooms/Stations	1	1	2
Total			
GSF of Main and Satellite ED's	19,051	10,210	29,261

5. **Section C, Need, Item 1 (Project Specific Criteria) Construction, Renovation, and Item 3.a**

   It is noted on the top of page 19 the ED visits in two zip codes have grown by 4.7% per year. Please clarify if this statement should be the "average of 4.7% per year" from 2010 to 2014.

   Response: This assertion is correct. The 4.7% annual growth stated is the average growth per year.

   Exhibit 5 on page 19 is noted. However, please clarify how the applicant derived the need of an additional 5 to 14 treatment/exam rooms on a 6 year growth of 5,399 ED visits using a standard of 1,500 per treatment/exam room.

Response: The projected need for 14 treatment rooms is discussed on page 17 of the application. It posits that if the actual State of Tennessee age cohort ED use rates for 2014 to 2020 are applied to the projected Sumner County population, there is projected growth of 14,442 additional visits. This reflects the disparity of current ED use rates within Sumner County compared to the surrounding counties and the state of Tennessee overall.

Based on a standard of 1,500 visits per emergency treatment room per year from the American College of Emergency Physicians, this incremental volume alone (14,442 visits) is sufficient to support 10 emergency treatment rooms at 100% utilization or 14 emergency treatment rooms at 70% utilization ((14,442 ÷ 1,500)÷ 70% = 13.75=14 treatment rooms).

Emergency visits decreased from 37,404 in 2012 to 37,147 in 2014 at SRMC's main campus. Why is there now a need for a satellite ER?

Response: Emergency visits at SRMC's main campus decreased slightly (less than 0.7%) over the two year period. This is a combination of 2.7% growth from 2012 to 2013 and a 3.3% loss from 2013 to 2014. Annualized data point to a 1.9% increase (rebound) for 2015.

This temporary decline in 2014 is directly attributable to the opening of the TriStar Portland (Sumner County) ER in January 2014. Added capacity in Portland resulted in a single-year volume decline at SRMC.

As demonstrated in the original CON application, ED visits from Sumner County residents have increased rapidly and are projected to continue growing. Population projections and natural aging both indicate a need for additional ED capacity, especially at SRMC. In 2012, SRMC had 23 ED treatment rooms. At 1,500 visits per room per year, the ED operated at 108.4% of capacity (or 90.3% of capacity at 1,800 visits per room per year). In 2014, SRMC added three rooms and still operated at 95.3% of capacity based on 1,500 visits per room per year (or 79.4% of capacity based on 1,800 visits per room per year.) Data for 2015 suggest that SRMC will soon reach utilization levels necessitating another increase in ED treatment rooms.

The number of ED visits reported for the Years 2010 to 2013 is noted in Exhibit 6. However, there appears to be discrepancies with figures reported in the joint annual reports. Please refer to the following table in addressing the following questions:

- Do the visits by payer include indigent and uninsured individuals?

  Response: Yes, the visits by payer include indigent and uninsured individuals.

- Why are there mostly a higher number of ER patients actually reported (A) in Exhibit 6 than what was reported as being treated by triage in (C) below?

  <u>**Response:**</u> The differences in the number of patients reported are due to the variety of different reporting systems utilized internally by SRMC. Depending on the source, whether it be the financial/billing system, the medical records system, or the ED documentation system, there can be slight variations in the patient volumes reported - one to three percent. These differences are neither significant nor material.

- Why are there more patients presented in ER in (D) than was reported as being treated in (A). Where did the difference of patients go?

  <u>**Response:**</u> As detailed in the response given above, the differences in the number of patients reported are due to the variety of different reporting systems utilized internally by SRMC. Depending on the source, whether it be the financial/billing system, the medical records system, or the ED documentation system, there can be slight variations in the patient volumes reported - one to three percent. These differences are neither significant nor material.

- Why was there not any patients referred to a physician or clinic for treatment and not treated in the ER?

  <u>**Response:**</u> Federal regulations require all hospitals to serve every patient presenting in the emergency department. Highpoint Health System operates its EDs "*to ensure that individuals coming to an affiliated Hospital's Dedicated Emergency Department seeking assessment or treatment for a medical condition, or coming to Hospital Property requesting (or obviously requiring) treatment for an Emergency Medical Condition receive an appropriate Medical Screening Examination as required by the Emergency Medical Treatment and Labor Act ("EMTALA")*". Please see **Attachment 1** for SRMC's EMTALA policy, which will also apply to the satellite ED.

  In practice, SRMC's policies and results are consistent with other Tennessee area hospitals.

  - There are eleven Tennessee hospitals within 25 miles of SRMC.
  - Three did not complete a 2013 JAR - NorthCrest Medical Center, TriStar Portland and TriStar Skyline Madison.

- Of the remaining eight, five did not refer out a single ER patient to a physician or clinic for treatment – Nashville General, Saint Thomas Midtown, TriStar Hendersonville, TriStar Summit, Trousdale Medical Center.

- Three hospitals – Macon County General, TriStar Skyline and University (Lebanon) – referred out a total of only 688 ER patients in 2013, or 0.75% of their combined 91,214 ER patients.

- Stated another way, the eight hospitals reporting on the 2013 JAR served 267,322 ER patients and referred out only 688 (0.26%) to physicians and clinics.

Conclusion – SRMC, like its peers, refers out few if any ER patients for treatment by a physician or clinic.

Total SRMC Main Campus ED Visits				
	2010	**2011**	**2012**	**2013**
A. Reported in Exhibit 6-Page 21 of application	**31,781**	**35,453**	**37,404**	**38,406**
# visits by payer				
B. Reported in Joint Annual Report Page 36	31,781	35,453	37,404	38,417
Difference in Exhibit 6 in application	**0**	**0**	**0**	**+6**
Triage # Actual Treated				
C. Reported in Joint Annual Report-Page 38	31,521	35,272	37,413	38,262
Difference in Exhibit 6	**-260**	**-181**	**+9**	**-144**
# of patients presented in ER				
D. Reported in Joint Annual Report Page 38	32,568	35,552	37,851	38,596
Difference In Exhibit 6	**+787**	**+99**	**+447**	**+190**
E. Total # not treated in ER but referred to physician or clinic for TX				

Reported in Joint Annual Report under Triage 8.C. Page 38	0	0	0	0

6. **Section C, Need, Item 3 (Service Area)**

Please provide a map of the entire state of Tennessee designating the applicant's declared service area counties. Please provide distinctive highlighting/ markings to readily differentiate the service area counties from the other non-service area counties.

Response: Please see **Attachment 2** for a map detailing the applicant's declared service area, Sumner County.

7. **Section C, Need, Item 4.A. and 4.B.**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each zip code in your proposed service area.

Variable	*Zip Code 37066*	*Zip Code 37075*
Current Year (CY), Age 65+[4]	*N/R*	*N/R*
Projected Year (PY), Age 65+	*N/R*	*N/R*
Age 65+, % Change	*N/R*	*N/R*
Age 65+, % Total (PY)	*N/R*	*N/R*
CY, Total Population	*N/R*	*N/R*
PY, Total Population	*N/R*	*N/R*
Total Pop. % Change	*N/R*	*N/R*
TennCare Enrollees[5]	*N/R*	*N/R*
TennCare Enrollees as a % of Total Population	-	-
Median Age[6]	*38.4*	*39.0*
Median Household Income	*$49,632*	*$63,464*
Population % Below Poverty Level	*12.9%*	*8.7%*

Please indicate if there are any medically underserved areas in either zip code 37066 or 37075.

[4] Tennessee Department of Health population data projections only calculated at a county level.
[5] TennCare enrollees are only reported at a county level.
[6] Census Bureau, 2013 data (Median age, median household income, and poverty status)

Response: Yes, there are two medically underserved areas (census tracts) in zip code 37066, CT 0207.00 and CT 0208.00.

8. **Section C, Need, Item 5.**

Exhibit 13 of the top hospitals serving Sumner County ED patients is noted. Please indicate where the approximate remaining 10% of patients originating in Sumner County in 2012, 2013, and 2014 go for emergency department services.

Response: Please see **Attachment 3** for a listing of hospitals that treated the remaining 10% of Sumner County ED patients for 2012, 2013 and 2014.

The use of the Tennessee Hospital Association Market IQ Data in Exhibit 13 is noted. Please use the THA Market IQ Data to complete the following table of emergency department patient origin for Zip Codes 37066 and 37075 for hospitals with a market share over 3%.

Zip Code 37066						
	2012		**2013**		**2014**	
Facility	**Visits**	**%**	**Visits**	**%**	**Visits**	**%**
Sumner Regional Medical Center	18,628	72.6%	18,969	72.9%	20,293	73.3%
TriStar Hendersonville Medical Center	3,758	14.7%	3,835	14.7%	3,826	13.8%
Vanderbilt University Hospitals	1,111	4.3%	1,112	4.3%	1,089	3.9%
All Others	2,151	8.4%	2,122	8.1%	2,484	9.0%
Total	**25,648**	**100.0%**	**26,038**	**100.0%**	**27,692**	**100.0%**
Zip Code 37075						
	2012		**2013**		**2014**	
Facility	**Visits**	**%**	**Visits**	**%**	**Visits**	**%**
TriStar Hendersonville Medical Center	15,386	68.3%	15,231	68.9%	15,834	68.7%
Vanderbilt University Hospitals	2,033	9.0%	1,923	8.7%	1,824	7.9%
TriStar Skyline Medical Center	1,506	6.7%	1,416	6.4%	1,631	7.1%
Sumner Regional Medical Center	1,058	4.7%	1,109	5.0%	1,105	4.8%
All Others	2,532	11.2%	2,412	10.9%	2,641	11.5%
Total	**22,515**	**100.0%**	**22,091**	**100.0%**	**23,035**	**100.0%**

Sumner County Emergency Departments	ER Rooms	2012 Visits	2013 Visits	2014 Visits	12-14 % Change	2014 Average Per Room
Hospital						
Sumner Regional Medical Center	26	37,193	37,953	36,832	-1.0%	1,417
TriStar Hendersonville Medical Cntr	15	31,366	31,558	32,828	4.7%	2,189
TriStar Portland ER	8	-	-	10,567	-	1,321
Total	49	68,559	69,511	80,227	17.0%	1,637

Please complete the following table:
Source: THA MarketIQ data

9. **Section C, Need, Item 6.**

Please identify existing urgent care centers in the applicant's service area by completing the table below.

Response: For the purposes of this table, urgent care centers (as opposed to walk-in clinics) typically have at least one medical doctor on staff, and offer care to higher acuity patients.

Urgent Care Centers in Applicant's Proposed Service Area

Urgent Care Center Name	Address	Distance from Proposed ED	Operating Hours
Gallatin Urgent Care	728 Nashville Pike Gallatin, TN 37066	5.7 miles	M-F 8AM-5:30PM, Sat 9AM-1:30PM, Sun CLOSED
American Family Care	291 Indian Lake Blvd Hendersonville, TN 37075	5.7 miles	7 days a week 8AM-6PM
TriStar Health CareSpot Urgent Care	280 Indian Lake Blvd Hendersonville, TN 37075	5.8 miles	7 days a week 8AM-8PM

Please complete the following table for SRMC patients treated and projected to be treated by level of care (level 1 corresponds to CPT code 99281 (lowest acuity patient), Level 2 (CPT Code 99282), Level 3 (CPT Code 99283), Level 4 (CPT Code 99284), while level 5 corresponds to (CPT Code 99285 - highest acuity patient).

SRMC Historical and Projected ED Utilization by Levels of Care

	2013	2014	2015	2016	Project Yr. 1 2017	Project Yr. 2 2018
Main ED						
Level I	1,801	1,480	1,508	1,561	1,413	1,462
Level II	1,991	1,673	1,704	1,764	1,597	1,653
Level III	12,108	11,657	11,874	12,290	11,126	11,515
Level IV	11,694	11,525	11,739	12,150	10,999	11,384
Level V	10,809	10,812	11,013	11,398	10,318	10,680
Sub Total	38,403	37,147	37,838	39,162	35,453	36,694
Satellite ED						
Level I					231	239
Level II					261	270
Level III					1,817	1,880
Level IV					1,796	1,859
Level V					1,685	1,744
Subtotal					5,789	5,992
Total Combined ED's					41,242	42,686

10. **Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3**
Please indicate what is included in "other costs" in the amount of $676,200 in A.9 in the Project Costs Chart.

Response: This represents the costs of permits, communications infrastructure, project development fees paid to outside consultants (excluding Architectural and engineering fees), and internal company costs allocated from the applicant's

Corporate office, which includes an administrative fee, and an imputed capitalized interest.

Please indicate the cost of the facility and revise the Project Costs Chart. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.

Response: The Sumner Station facility was constructed in 2008. SRMC purchased the facility in December 2013. The facility is owned by SRMC, not leased, and there is no lease payment associated with the proposed project. The proposed renovations associated with the satellite ED project are the equivalent of renovating the space at the main hospital facility.

The area containing the proposed satellite ED is not new space and, as such, the applicant has not revised the Project Costs chart to reflect any additional costs.

11. Section C, Economic Feasibility, Item 2 and Orderly Development Item 8 and 9

The funding letter is noted. However, since the project will be funded from cash reserves, please revise the funding letter stating the proposed project will be funded from Life Point's cash reserves.

Response: Please see **Attachment 4** for a revised funding letter.

12. Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)

The Projected Data Chart for the proposed satellite emergency department is noted. However, please explain the reason why there is no charity care assigned in Year 1 and Year 2 while on the top of page 39 the applicant notes charity care in the amount of $120,000.

Response: Charity care was included in the contractual adjustments and bad debt rather than listed separately. The satellite ED at Sumner Station will offer the same Charity Care program as that of the main Campus. Please see **Attachment 5** for a copy of SRMC's Charity Care policy. Please see **Attachment 6** for a revised projected data chart for the satellite ED that breaks out charity care from the contractual adjustments and bad debt.

Please clarify what the $255,000 E/R Physician Coverage Subsidy in the other expenses category represents in the Projected Data Chart for the proposed satellite emergency department.

Response: The $255,000 represents the cost of physician coverage for the satellite ED, which will be contracted out to Sumner Emergency Physicians, LLC, an independently owned ER Physician group, which already provides physician coverage at the Emergency Department on SRMC's main campus.

Please provide a Historical and Projected Data Chart for SRMC's Emergency Department.

Response: Please see **Attachments 7 and 8** for a Historical and Projected Data Chart for SRMC's Emergency Department.

Please provide a Projected Data Chart for the total hospital.

Response: Please see **Attachment 9** for a Projected Data Chart for the total hospital.

13. Section C, Economic Feasibility, Item 6

Exhibit 18 is noted on the top of page 37. Please discuss what the service mix index is and how it is applied to this exhibit.

Response: The service mix index is a measure of patient acuity used by CMS for Medicare patients to differentiate levels of patient care required. The higher the index value, the greater the patient's needs and the greater the provider's reimbursement.

To compare charges from one facility to another, one must first adjust for different levels of patient acuity at each facility. This is accomplished by dividing the facility average charge by the facility service mix index, or comparing charges at all facilities as if they had a common service mix index equal to 1.00.

Please compare the proposed satellite ED charges to proposed charges of similar satellite ED projects recently approved by the Health Services and Development Agency.

Response: Please see the table below which compares gross charges per visit for SRMC, Gateway Medical Center, and Northcrest Medical Center's recent satellite ED projects.

Projected Gross Charge Per Visit		
Year 1		
SRMC	Gateway	Northcrest
$3,148	$3,307	$1,381

Sources: Internal data, Gateway/Northcrest CON submissions

14. Section C, Economic Feasibility, Item 9

The estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation is noted. However, it appears to percentages do not correspond with the proposed satellite ED projected data chart. Please clarify.

Response: Please see the completed table below for the applicant's historical and projected payor mix at both the main hospital ED and the proposed satellite ED.

The participation of the proposed ED facility in state and federal programs is noted. However, please also provide the overall payor mix projected for both the main campus ED and the proposed satellite ED in Year 1 by completing the table below.

Applicant's Historical and Projected Payor Mix

Payor Source	Main ED Gross Operating Revenue 2014	As a % of Gross Operating Revenue 2014	Main ED Gross Operating Revenue Year 1	As a % of Gross Operating Revenue Year 1	Satellite ED Gross Operating Revenue Year 1	As a % of Gross Operating Revenue
Medicare	40,173,912	29.46%	32,878,603	29.46%	5,368,635	29.46%
TennCare	31,890,420	23.39%	26,099,337	23.39%	4,261,672	23.39%
Managed Care	35,108,130	25.75%	28,732,733	25.75%	4,691,670	25.75%
Commercial	2,397,943	1.76%	1,962,493	1.76%	320,449	1.76%
Self-Pay	22,584,622	16.56%	18,483,408	16.56%	3,018,093	16.56%
Other	4,210,529	3.09%	3,445,925	3.09%	562,673	3.09%
Total	136,365,556	100%	111,602,499	100%	18,223,193	100%

Source: Internal data

15. Section C, Economic Feasibility, Item 9

Please clarify if the applicant conducted a feasibility study of expanding the main ED and what that cost would be.

Response: The applicant did not conduct a feasibility study of expanding the main ED. As discussed in the main application, SRMC added three additional ED patient treatment rooms in 2014. This moderate expansion was accomplished inexpensively through the conversion of existing office space. Unfortunately, there is no longer any additional "soft" space available for conversion to clinical use. SRMC has thoroughly maximized the footprint of its current ED service, and there is simply no internal/adjacent expansion capacity remaining.

As detailed above, SRMC's main campus ED is located in a walk-in type basement level of the main hospital.

- It is impractical and cost prohibitive to tunnel into subterranean areas below the existing property grade.
- Portions of the outer walls of the ED space border on adjacent property not owned by SRMC.
- The remaining outer walls (the "walk-in" portions) open to the ED patient entrance and ambulance entrance/parking area. These entrances cannot be moved and the parking cannot be reduced.
- Though the ED is adjacent to radiology, relocating radiology to new construction would prove extremely expensive due to the highly fixed nature of the service's equipment and special shielding, electrical and cooling requirements. Furthermore, radiology relocation would result in transport and screening delays for all inpatients and outpatients.

Due to these facility constraints, SRMC's only ED expansion option is to add newly constructed space. For this option, Sumner Station was deemed more appropriate than the main campus.

Please address the cost/benefit of having to transfer satellite ED patients by ambulance to the main ED vs. expanding the main ER and not having any ambulance expense.

Response: In calendar year 2014, approximately 15.25% of SRMC emergency department patients were admitted as an inpatient and approximately 5.32% were admitted as an observation patient.

As these data indicate, more than three quarters of ER patients do not require a bed of any type, be it a regular inpatient bed or an observation bed. For the vast majority of ER patients, care at a satellite ER can be delivered more quickly, closer to home, with less travel time to downtown Gallatin.

For the minority of ER patients who do require a bed of some type for at least a few hours, care at a satellite ER also can be delivered more quickly, closer to home and with less travel time to downtown Gallatin. Every minute counts in a true emergency. An ambulance transfer is a minor inconvenience compared to more quickly stabilizing a patient in an emergent and potentially life threatening condition.

16. Section C, Orderly Development, Item 1.

The list of managed care and provider contracts under Attachment, Orderly Development-1 is noted. However, the attachment could not be located. Please clarify.

Response: This reference was a typographical error. The sentence should read "Lists of managed care *organizations* and provider *organizations with which SRMC has contracts* are attached under Attachment C, Contribution to the Orderly Development of Health Care - 1." The attachment being referenced is included at Tab 6 of the original application.

Please indicate where emergency OB patients will be referred for treatment from the proposed satellite facility. Also, please clarify if the OB patients would be admitted directly to the receiving facility, or would need to admit through the receiving hospital's ED.

Response: Like other patients described above, OB patients will be transferred to Sumner Regional Medical Center. These OB patients will be admitted directly to the receiving facility via SRMC's OB triage area. Already registered at SRMC through the Satellite ED admission and intake processes, there would be no need to be admitted a second time through the receiving hospital's ED.

We hope these responses are sufficient to deem this CON application complete. A notarized affidavit is provided in **Attachment 10**.

I may be reached by phone at 615-328-6695 or by email at Michael.Herman@LPNT.net to clarify any other matters.

Sincerely,

Michael Herman
Chief Operating Officer
Sumner Regional Medical Center

Attachments

SUPPLEMENTAL #1

August 25, 2015

2:15 pm

Attachment 1

SUPPLEMENTAL #1
August 25, 2015
2:15 pm

Current Status: *Active* **PolicyStat ID:** *1011593*

SUMNE
Regional Medical Ce
HIGHPOINT HEALTH SYST

Effective:	
Approved:	
Last Revised:	
Expiration:	
Policy Area:	*Risk Management*
Applicability:	*Sumner Regional Medical Center*

EMTALA- Medical Screening and Treatment of Emergency Medical Conditions

SCOPE:

All HighPoint Health System-affiliated facilities including Hospitals and any entities operating under the Hospital's Medicare Provider Number including, but not limited to, the following:

All Clinical Departments	Administration
Ancillary Services	Quality Management
Admitting/Registration	Risk Management
Employed Physicians	Emergency Department
Hospital owned Medical Office Buildings	Urgent Care Centers/Clinics
Nursing	Finance
Hospital Department (on and off campus)	
Hospital Based Entity (on campus)	

PURPOSE:

To ensure that individuals coming to an affiliated Hospital's Dedicated Emergency Department seeking assessment or treatment for a medical condition, or coming to Hospital Property requesting (or obviously requiring) treatment for an Emergency Medical Condition receive an appropriate Medical Screening Examination as required by the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C., Section 1395 and all Federal regulations and interpretive guidelines promulgated thereunder, and, if an Emergency Medical Condition is determined to exist, such individuals are offered stabilizing treatment within the Hospital's capabilities and/or are transferred if appropriate, all without regard to the patient's insurance coverage or ability to pay.

POLICY:

Any individual who comes to the Hospital Property or Premises requesting examination or treatment is entitled to and shall be provided an appropriate Medical Screening Examination performed by a physician or other Qualified Medical Personnel to determine whether or not an Emergency Medical Condition exists.

If an Emergency Medical Condition is found to exist, the Hospital will (without regard for the patient's insurance coverage or ability to pay) provide: (a) stabilizing treatment within the capabilities of the Hospital and its staff (including on-call physicians and diagnostic services), and/or (b) an appropriate transfer to another medical facility (if required for the patient's treatment or requested by the patient).

PROCEDURE:

1. DEFINITIONS:
   - **Appropriate transfer** occurs (once a physician has certified the need for transfer or the patient has requested transfer after an explanation of the risks and the Hospital's obligation to provide stabilizing services) when:
     i. the transferring Hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and in the case of a woman in labor, the health of the unborn child;
     ii. the receiving facility has the available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and to provide appropriate medical treatment;
     iii. the transferring Hospital sends to the receiving Hospital all medical records (or copies thereof) related to the Emergency Medical Condition for which the individual has presented, available at the time of transfer, including records related to the individual's Emergency Medical Condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of diagnostic studies or telephone reports of the studies, and the informed written consent or certification required, name and address of any on-call physician who has refused or failed to appear

within a reasonable time to provide necessary stabilizing treatment, and that any other records that are not readily available at the time of transfer are sent as soon as practicable after the transfer; and

iv. the transfer is effected through qualified personnel, transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

- **Campus** means the physical area immediately adjacent to the main Hospital, other areas and structures that are not strictly contiguous to the main Hospital buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the main Hospital's campus.
- **Capabilities** of a Hospital provider means the physical space, equipment, supplies and services (*e.g.*, trauma care, surgery, intensive care, pediatrics, obstetrics, burn unit, neonatal unit or psychiatry), including ancillary services, available to Hospital patients. The capabilities of the Hospital's staff mean the level of care that the Hospital's personnel can provide within the training and scope of their professional licenses. For off-campus departments, the capability of the Hospital as a whole is included. The obligations of the Hospital provider must be discharged within the Hospital as a whole.
- **Capacity** means the ability of the Hospital to accommodate the individual requesting examination or treatment of the transferred individual at the time in question. Capacity encompasses number and availability of qualified staff, beds, equipment and consideration of the Hospital's past practices of accommodating additional patients in excess of its occupancy limits.
- **Central Log** is a log that a Hospital is required to maintain on each individual who comes to its emergency department or any location on the Hospital Property or Premises seeking assistance and that contains the disposition of each individual, whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged. The purpose of the central log is to track the care provided to each individual who comes to the Dedicated Emergency Department seeking examination or treatment for a medical condition, or who comes to the Hospital Property or Premises seeking care for an Emergency Medical Condition. The central log includes, directly or by reference, patient logs from other areas of the Hospital, such as pediatrics and labor and delivery, which may also be Dedicated Emergency Departments where a patient might present for emergency services or receive a Medical Screening Examination instead of in the traditional emergency department. The requirements for the Central Log are described in more detail in SF 904 EMTALA – Central Log.
- **Dedicated Emergency Department:** A department of the Hospital, that can be either on or off the campus, which meets one or more of the following conditions:

  1. Licensed by that state as an emergency department;

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2:15 pm

2. Held out to the public as providing care for emergency medical condition(s) on an urgent basis without an appointment; or
3. An outpatient treatment location which, in the last calendar year, provided at least one-third of all outpatient visits (based on random sample) for the treatment of Emergency Medical Conditions without requiring a previously scheduled appointment.
   Note that a Hospital may have more than one location that satisfies the definition of "Dedicated Emergency Department."

Department of Hospital means a division of the Hospital through which the Hospital furnishes health care services of the same type as those furnished by the Hospital under the name, ownership, provider certification, and financial and administrative control of the Hospital, whether on or off campus. A department of a Hospital may not be licensed to provide health care services in its own right and may not by itself be qualified to participate in Medicare as a provider. The Medicare Conditions of Participation do not apply to a department as an independent entity but apply to the department as a part of the Hospital.

Emergency Medical Treatment and Active Labor Act ("EMTALA") refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, which obligates Hospitals to provide medical screening, treatment and transfer of individuals with Emergency Medical Conditions or women in labor. It is also referred to as the "anti-dumping" statute and COBRA.

Emergency Medical Condition means:

0. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
   a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part; or
1. With respect to a pregnant woman who is having contractions:
   a. That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
   b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital means a main hospital provider that has entered into a Medicare Provider Agreement, including a critical access or rural primary care hospital. For the purpose of these policies, hospital refers to the main building in which the emergency department is located.

Hospital Property or Premises means the entire Hospital campus, including the parking lot, sidewalk, driveway, and common areas in Hospital-owned MOBs on campus, as well as any facility or organization that is located off the Hospital campus but satisfies the definition of Dedicated Emergency Department. Hospital Property or Premises excludes those locations on the campus that are either operated under a Medicare provider number that is different than the Hospital's, or that are not under the control of the Hospital, whether such location is used for medical or non-medical purposes (such as private medical offices, gift shops not operated by the Hospital).

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or qualified medical personnel acting within his or her scope of practice as defined in hospital medical staff bylaws and State law certifies that, after a reasonable period of observation, the woman is in false labor. The Hospital should specify in its medical records policies the mechanisms which may be utilized for such certification.

Medical Screening Examination is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an Emergency Medical Condition exists or a woman is in labor. Such screening must be done within the facility's capability and available personnel, including on-call physicians. The Medical Screening Examination must be performed by a Physician or other Qualified Medical Personnel. The Medical Screening Examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and must continue until the patient is either stabilized or appropriately transferred. Triage does not constitute a Medical Screening Examination.

Movement from Off-Campus Department means the movement of a patient from an off-campus department to the main Hospital campus. Movement of the individual from the off-campus department to the main Hospital campus is not considered a transfer.

On-Call List refers to the list that the Hospital is required to maintain which defines those physicians who are "on-call", directly or by arrangement, to assist the emergency department physician or QMP in the care of the patient after the initial Medical Screening Examination, to provide further evaluation and/or treatment necessary to stabilize an individual with an Emergency Medical Condition. The purpose of the on-call list is to ensure that the emergency department is prospectively aware of which physicians, including specialists and sub-specialists, directly or by arrangement, are available to provide treatment necessary to stabilize individuals with Emergency Medical Conditions. If a Hospital offers a service to the public, the service should be available to patients of the emergency department. Additional requirements regarding the On-Call

List are contained in Policy SF 906 (EMTALA – Provision of On-Call Coverage).

Physician means: (i) a doctor of medicine or osteopathy; (ii) a doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his/her license; (iii) a doctor of podiatric medicine to the extent that he/she is legally authorized to perform by the State within the scope of his/her license; or (iv) a doctor of optometry to the extent that he/she is legally authorized to perform by the State within the scope of his/her license.

Physician Certification refers to written certification by the treating physician ordering the transfer and prior to the patient's transfer, that based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer. The certification shall include a summary of the risks and benefits upon which the certification is based and the reason(s) for the transfer. If a physician is not physically present at the time of transfer, a QMP can sign the certification as long as the QMP is in consultation with the physician and the physician is in agreement with the certification and subsequently countersigns the certification.

Prudent Layperson describes any non-medically trained but reasonably attentive observer.

Qualified Medical Person or Personnel, or "QMP", means an individual other than a licensed physician who has demonstrated current competence in the performance of Medical Screening Examinations and been approved by the main Hospital provider's governing board as qualified to administer one or more types of Medical Screening Examination and complete/sign a certification for transfer in consultation with a physician. The non-physician practitioners designated as QMPs must be set forth in a document that is approved by the governing body of the Hospital. Ad hoc QMP designations are not permissible.

Signage refers to the Hospital requirement to post signs conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department, (*e.g.,* outpatient departments, on campus Hospital based entities, labor and delivery, waiting room, admitting area, entrance and treatment areas), informing the patients of their rights under Federal law with respect to examination and treatment for Emergency Medical Conditions and women in labor. The sign must also state whether or not the Hospital participates in the State's Medicaid program. Specific Signage requirements are described in Policy SF 905 (EMTALA-Signage).

Stabilized with respect to an Emergency Medical Condition means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from the facility or in the case of a woman in labor, that the woman delivered the child and the placenta. A patient will be deemed stabilized if the treating physician of the individual with an Emergency Medical Condition has determined, within reasonable clinical confidence, that the Emergency Medical Condition has been resolved.

To Stabilize means, with respect to an Emergency Medical Condition to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or, in the case of a woman in labor, that the woman has delivered the child and the placenta.

Stable for Discharge: A patient is considered stable for discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions. For the purpose of discharging a patient with psychiatric condition(s), the patient is considered to be stable for discharge when he/she is no longer considered to be a threat to him/her or to others.

Transfer means the movement of an individual outside a Hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of an individual who has been declared dead or who leaves the facility against medical advice or without being seen.

Triage is a sorting process to determine the order in which patients will be provided a Medical Screening Examination by a physician or qualified medical person. Triage is not the equivalent of a Medical Screening Examination and does not determine the presence or absence of an Emergency Medical Condition.

Facility Policies

Each Hospital that provides emergency medical services must develop policies and procedures to insure compliance with EMTALA requirements. Such policies should contain the following provisions:

. **General Requirements: Registration, Triage, and MSE.**

0. **Registration and Log**
   Each such presenting individual must be listed in the Central Log described in more detail in Policy SF 904 (EMTALA – Central Log). The MSE may not be delayed in order to secure the individual's insurance information or payment arrangements. Hospitals should request this information only after the MSE has begun.
   Patients who inquire about financial responsibility for emergency care will be encouraged to delay such discussion until after the Medical Screening Examination has begun. These patients should also be told that the Hospital will provide an MSE and stabilizing treatment, regardless of the patient's ability to pay.
   Hospitals are prohibited from seeking prior authorization for the screening or

stabilizing services from the individual's insurer or managed care organization. Each Hospital should ensure that it uses a reasonable registration process that does not delay screening or treatment and does not unduly discourage individuals from remaining for further evaluation.

1. **Triage**
   The Hospital should utilize the Triage Process to determine the order in which patients receive an MSE and further treatment as necessary. Triage does **not** determine the presence or absence of an Emergency Medical Condition.

2. **Medical Screening Examination (or "MSE")**
   In general, when an individual (who is not a Hospital inpatient or a registered outpatient in the course of an appointment)

   - comes to a Dedicated Emergency Department and requests assessment or treatment for a medical condition (whether or not the individual believes it to be an emergency), or the request is made on the individual's behalf; or

   - presents to a location on the Hospital Property other than the Dedicated Emergency Department and a requests examination or treatment of an Emergency Medical Condition (or such request is made on the individual's behalf), or a Prudent Layperson would recognize that the individual needs emergency assistance

   the Hospital must provide for an appropriate Medical Screening Examination ("MSE") conducted by a physician or other QMP, including to the extent necessary ancillary services within the Hospital's capabilities and on-call physician services, to determine whether or not an Emergency Medical Condition exists (or with respect to a pregnant woman having contractions, whether the woman is in labor).
   Provision of the MSE is required regardless of the Hospital's size or payor mix. Hospitals shall not discriminate against any individual seeking such services because of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, color, national origin, or handicap. An MSE is required each time a patient presents to the DED (or elsewhere on Hospital Property as described above).
   Depending on the patient's presenting symptoms, the Medical Screening Examination may range from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures. A Medical Screening Examination is not an isolated event. It is an on-going process. The record must reflect continued monitoring according to the patient's needs and must continue until he/she is stabilized or appropriately transferred. There should be evidence of this evaluation documented in the

medical record prior to discharge or transfer. Emergency department physicians and QMPs may consult with the patient's primary care physician or other physician who is treating the patient for information and guidance so long as the MSE is not delayed while awaiting physician response.

Location of MSE

The Hospital may move the patient to other Hospital-owned facilities that are on-campus or contiguous to the Hospital in order to access appropriate services as part of the MSE or subsequent stabilizing treatment. For example, all pregnant women may be directed to the labor and delivery area of the Hospital (whether or not that area constitutes a Dedicated Emergency Department). The Hospital may deliver emergency services in areas of the Hospital that are also used for other inpatient or outpatient services. However, movement of the patient to other Hospital-owned facilities on the campus or contiguous to the campus during the MSE process may only occur when these three conditions are satisfied:

- All persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
- There is a bona fide medical reason to move the patient, and
- Qualified medical personnel accompany the patient.

Such movement does not constitute a transfer. Patients should not be moved to off-campus departments of the Hospital in the course of the MSE. Note that it is not appropriate to move a patient to a physician office, even if on campus, for completion of the MSE or stabilizing treatment.

Who May Perform MSE

A Medical Screening Examination may be performed by an emergency department physician, another physician, or a non-physician practitioner who is qualified to conduct such examination ("Qualified Medical Personnel" or "QMP") and approved by the Hospital's governing board:

a. Medical Screening Examinations must be performed by an emergency department physician, another physician or a non-physician practitioner who is qualified to conduct such examination.
b. A qualified medical person may conduct the Medical Screening Examination provided the individual is:
    i. Determined qualified by Hospital medical staff bylaws, rules and regulations which are approved by the Hospital's Board of Trustees or other governing body, and

ii. Functioning within the scope of his or her license and in compliance with State law and applicable State nurse and medical practice acts.

c. When non-physician personnel perform Medical Screening Examinations, the Hospital's Governing Body and the appropriate medical staff committees should approve specific screening protocols that outline the examination and/or diagnostic work-up required to determine if an Emergency Medical Condition exists. These protocols will normally be complaint specific and will be limited to those presenting complaints that lend themselves to screening by such non-physician personnel.

d. The competencies for any non-physician personnel performing Medical Screening Examinations should be documented and validated by a qualified physician. There should also be an education plan for measuring and developing core competencies in medical screening.

e. Hospitals must establish a process to ensure that an emergency department physician examines all patients whose conditions or symptoms require physician examination.

f. Hospitals must establish processes to ensure that 1) an emergency department physician on duty is responsible for the general care of all patients presenting themselves to the emergency department; and 2) the responsibility remains with the emergency department physician until the patient's private physician or an on-call specialist assumes that responsibility, or the patient is discharged.

A. **Results of MSE; Additional Obligations; Stabilizing Treatment.**

0. **Results of MSE and Attendant Responsibilities**
In general, if the physician or other QMP performing the MSE determines that the individual does **not** have an Emergency Medical Condition, then the Hospital's EMTALA obligations to that individual cease. The Hospital may proceed to collect financial information and make financial arrangements for treatment.
If the MSE reveals an Emergency Medical Condition, then the Hospital must provide stabilizing treatment within its capacity and capabilities (including on-call physician services and ancillary services) necessary to stabilize the patient or must appropriately transfer the patient to another facility. Admission as an inpatient may be required as part of the stabilizing treatment. Once a patient is admitted as an inpatient in good faith, EMTALA is satisfied; however, the Hospital continues to have responsibility to meet patient emergency needs in accordance with the Medicare Conditions of Participation.
The Hospital may not condition or appear to condition the provision of stabilizing

treatment on the patient's ability to pay. A patient should not be asked for payment until the patient has received the MSE and been stabilized, generally as part of the check out process when being discharged or in accordance with the Hospital's usual procedures regarding inpatients, if the patient is being admitted.

1. **Stable for Discharge**
   A patient will be deemed stable for discharge if the treating physician attending to the patient in the Hospital emergency department has determined within reasonable clinical confidence that the patient has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions. With respect to an individual with a psychiatric condition, the patient is considered to be stable for discharge when the physician has determined that the patient is no longer considered to be a threat to him/her or to others. Note that this status does not necessarily require the final resolution of the medical condition underlying the Emergency Medical Condition. However, it is never appropriate to discharge to another Hospital's emergency department

2. **Transfer Requirements**
   If the MSE reveals an Emergency Medical Condition, the patient may only be transferred while the condition has not been stabilized **if**: (a) the physician has certified that the medical benefits to be received at another Hospital outweigh the increased risks to the individual (and, as the case may be, to her unborn child) or (b) the patient, or a legally responsible person acting on the patient's behalf, requests the transfer, after being informed of the Hospital's obligations under EMTALA and of the risks and benefits of the transfer, among other requirements. Patients should not generally be transferred to a lower level of care (for example, patients should never be transferred to a physician office).
   For a complete description of transfer requirements, please see Policy SF 903 (EMTALA – Transfers).

B. **Special Circumstances: Ambulances**.

   0. A Hospital-owned ambulance is considered "Hospital Property" regardless of its location for purposes of determining whether an individual present on Hospital Property requests emergency medical treatment (or such a request is implied).

   1. An individual being transported by ambulance (other than an ambulance owned or operated by the Hospital) is not considered to have arrived requesting treatment until they reach the Hospital Property, even if the ambulance personnel are in electronic or telephonic with emergency department personnel.

   2. A Hospital may deny access to patients when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time. Hospitals may not divert on a case-by case basis, but may only divert

when on formal diversionary status. However, if an ambulance disregards the Hospital's instructions regarding diversion and brings the individual to the Hospital, the individual has come to the Hospital, and the Hospital's EMTALA duties are triggered.

3. When helicopters and ambulances not owned by the Hospital enter Hospital grounds for the sole purpose of conveying a patient to another vehicle for transport to another Hospital, EMTALA obligations are not triggered **unless** the ambulance or helicopter crew requests assistance with the management of a patient. If such assistance is requested, the Hospital must meet all EMTALA obligations to the patient for whom assistance was requested.

C. **Special Circumstances: Withdrawal of Request for Examination.**

0. If a patient withdraws his or her request for examination or treatment, an appropriately trained individual from the emergency department staff should discuss the medical issues related to a voluntary withdrawal. In the discussion, the emergency department staff member should:

   . Offer the patient further medical examination and treatment as may be required to identify and stabilize an Emergency Medical Condition;

   a. Inform the patient of the benefits or the examination and treatment, and of the risks of withdrawal prior to receiving the examination and treatment; and

   b. Use reasonable efforts to get the patient to sign a form indicating that the patient has refused the recommended examination and/treatment. The form should contain a description of risks discussed and of the examination and/or treatment that was refused.

1. If a patient leaves the Hospital without notifying Hospital personnel, this should be documented. The documentation must reflect that the patient had been at the Hospital and the time the patient was discovered to have left the premises. Triage notes and additional records must be retained. The patient should still be included in the Central Log, with documentation that the patient left without notification.

D. **Special Circumstances: When MSE Is Not Required**

0. No MSE is required if a patient presents to the DED and requests **solely** one of the following preventative services: immunizations, allergy shots, or flu shots. However, Hospitals should be cautious of this exception as it must be clear to all involved the precise nature of what is being requested.

1. No MSE is required if law enforcement brings an individual requesting only a blood alcohol test and no other requests are made or implied. Hospitals should be cautious as a request for clearance for incarceration would require an MSE, as would a patient for whom law enforcement was requesting only a blood alcohol test but it would be apparent to a prudent layperson that the individual has sustained

injuries or been involved in an accident such that he should be examined for the presence of an Emergency Medical Condition (must provide such patient with an MSE).

2. Off-campus facilities that do not meet the definition of Dedicated Emergency Departments must have written policies and procedures for appraisal of emergencies and provision of initial treatment and referral in accordance with the Medicare Conditions of Participation. EMTALA does not apply in such situations.

REFERENCES:

Social Security Act, Section 1867 (42 USC §1395dd) Examination and Treatment for Emergency Medical Conditions and Women In Labor
CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases
42 CFR Part 482 Conditions of Participation for Hospitals
42 CFR 489.20 Basic Commitments
42 CFR 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases
The following Hospital-wide Risk Management EMTALA policies and procedures:
SF 903 EMTALA - Transfer Policy
SF 905 EMTALA - Signage Policy
SF 904 EMTALA - Central Log Policy
SF 907 EMTALA - Duty to Accept Policy
SF 906 EMTALA - Provision of On-Call Coverage Policy

SUPPLEMENTAL #1

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Attachment 2

SUPPLEMENTAL #1
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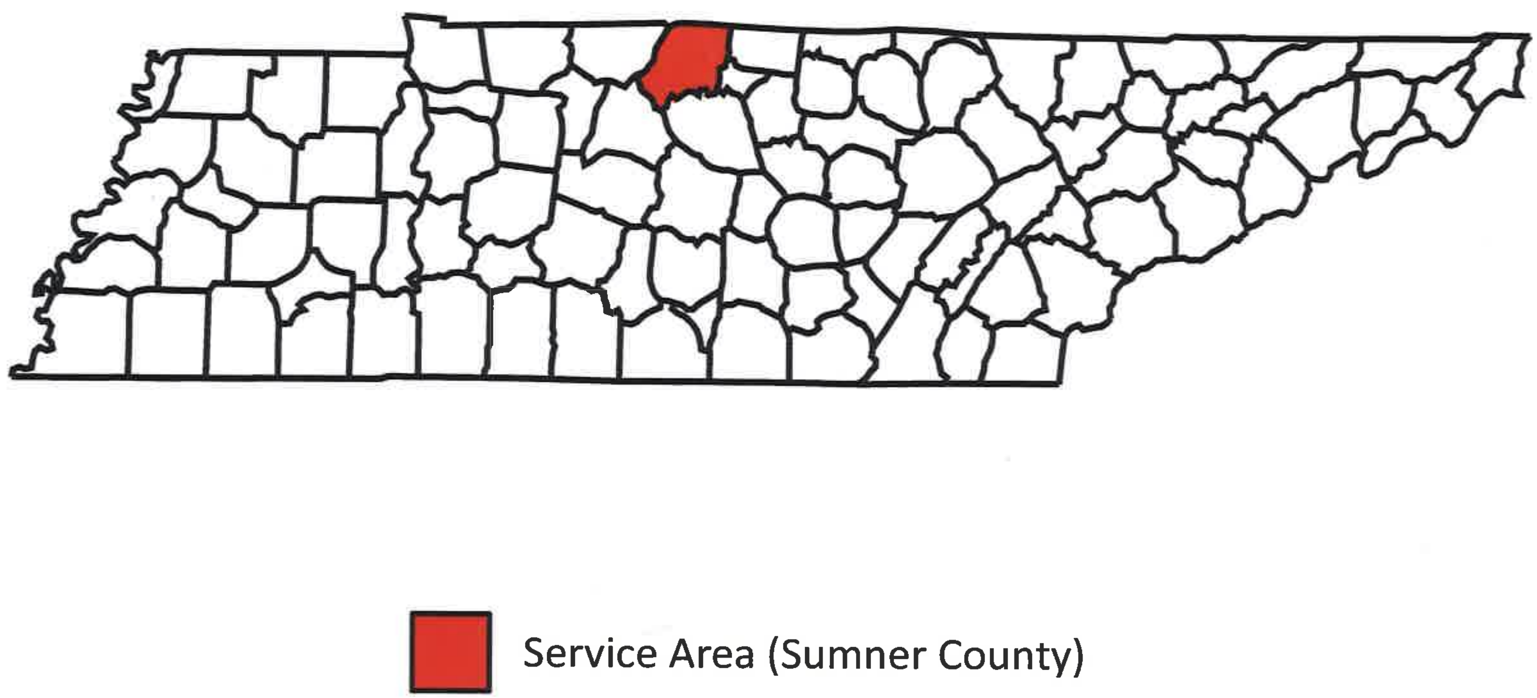
Service Area Map
Sumner Regional Medical Center
Satellite ED



SUPPLEMENTAL #1

August 25, 2015
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Attachment 3

SUPPLEMENTAL #1

August 25, 2015

2:15 pm

	2012		2013		2014	
Facility	Visits	%	Visits	%	Visits	%
TriStar Centennial Med Cntr	1,007	1.4%	1,145	1.6%	1,200	1.5%
Macon Co Gen Hosp	1,128	1.6%	1,130	1.6%	1,077	1.4%
Saint Thomas Midtown Hosp	1,164	1.7%	1,046	1.5%	985	1.3%
Saint Thomas West Hosp	775	1.1%	643	0.9%	747	1.0%
Trousdale Med Cntr	717	1.0%	614	0.9%	711	0.9%
Univ Med Cntr	625	0.9%	607	0.9%	639	0.8%
TriStar Summit Med Cntr	606	0.9%	598	0.9%	604	0.8%
NorthCrest Med Cntr	523	0.7%	488	0.7%	367	0.5%
Nashville Gen Hosp	234	0.3%	277	0.4%	235	0.3%
TriStar Southern Hills Med Cntr	153	0.2%	154	0.2%	166	0.2%
Saint Thomas Rutherford Hosp	113	0.2%	103	0.1%	143	0.2%
TriStar StoneCrest Med Cntr	99	0.1%	92	0.1%	120	0.2%
Williamson Med Cntr	73	0.1%	72	0.1%	87	0.1%
Riverview Reg Med Cntr	28	0.0%	68	0.1%	76	0.1%
Univ of TN Med Cntr	63	0.1%	87	0.1%	68	0.1%
Cookeville Reg Med Cntr	49	0.1%	66	0.1%	62	0.1%
Gateway Med Cntr	65	0.1%	58	0.1%	53	0.1%
TriStar Horizon Med Cntr	37	0.1%	46	0.1%	45	0.1%
Erlanger Med Cntr-Baroness Hosp	40	0.1%	37	0.1%	35	0.0%
TriStar Ashland City Med Cntr	34	0.0%	27	0.0%	34	0.0%
Maury Reg Med Cntr	22	0.0%	17	0.0%	33	0.0%
LeConte Med Cntr	30	0.0%	36	0.1%	31	0.0%
TriStar Skyline Madison Campus	18	0.0%	26	0.0%	18	0.0%
Ft Sanders Reg Med Cntr	20	0.0%	11	0.0%	13	0.0%
Cumberland Med Cntr	7	0.0%	5	0.0%	12	0.0%
TriStar Centennial ED Spring Hill		0.0%	4	0.0%	11	0.0%
Jackson-Madison Co Gen Hosp	16	0.0%	8	0.0%	11	0.0%
Parkridge Med Cntr	8	0.0%	3	0.0%	10	0.0%
SkyRidge Med Cntr	4	0.0%	8	0.0%	9	0.0%
Blount Memorial Hosp	9	0.0%	3	0.0%	9	0.0%
CHI Memorial Hosp-Chattanooga	7	0.0%	4	0.0%	9	0.0%
Harton Reg Med Cntr	11	0.0%	8	0.0%	9	0.0%
CHI Memorial Hosp-Hixson	10	0.0%	3	0.0%	8	0.0%
DeKalb Comm Hosp	7	0.0%	10	0.0%	8	0.0%
Parkwest Med Cntr	7	0.0%	10	0.0%	7	0.0%
Highlands Med Cntr	9	0.0%	3	0.0%	7	0.0%
Marshall Med Cntr	19	0.0%	9	0.0%	7	0.0%
United Reg Med Cntr		0.0%	2	0.0%	7	0.0%
River Park Hosp	10	0.0%	2	0.0%	7	0.0%
Three Rivers Hosp		0.0%	1	0.0%	6	0.0%
Johnson City Med Cntr	5	0.0%	9	0.0%	6	0.0%
Erlanger East		0.0%	5	0.0%	6	0.0%
Southern TN Reg Health Sys-Winche	6	0.0%	2	0.0%	6	0.0%
Saint Francis Hosp-Bartlett	4	0.0%	4	0.0%	6	0.0%
Tennova H-care-Turkey Creek Med C	3	0.0%	6	0.0%	6	0.0%
Methodist LeBonheur Germantown	2	0.0%	4	0.0%	6	0.0%
Tennova H-care-Physicians Reg Med	2	0.0%	6	0.0%	5	0.0%
Henry Co Med Cntr	8	0.0%	4	0.0%	5	0.0%
Dyersburg Reg Med Cntr	3	0.0%	2	0.0%	5	0.0%
Stones River Hosp	1	0.0%	1	0.0%	5	0.0%
Southern TN Reg Health Sys-Pulaski	5	0.0%	4	0.0%	5	0.0%
Tennova H-care-Jefferson Memorial H	5	0.0%	7	0.0%	5	0.0%
Wellmont Holston Valley Med Cntr	7	0.0%	1	0.0%	5	0.0%

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	2012		2013		2014	
Facility	Visits	%	Visits	%	Visits	%
Saint Francis Hosp	1	0.0%	3	0.0%	4	0.0%
Wellmont Bristol Reg Med Cntr	2	0.0%	6	0.0%	4	0.0%
McKenzie Reg Hosp	2	0.0%	2	0.0%	4	0.0%
BMH-Collierville	3	0.0%	1	0.0%	4	0.0%
BMH-Memphis	2	0.0%	3	0.0%	4	0.0%
Cumberland River Hosp	4	0.0%	7	0.0%	4	0.0%
Wayne Med Cntr		0.0%	1	0.0%	4	0.0%
East TN Children's Hosp	5	0.0%	6	0.0%	4	0.0%
Heritage Med Cntr	8	0.0%	8	0.0%	4	0.0%
Takoma Reg Hosp	1	0.0%	1	0.0%	3	0.0%
Methodist Univ Hosp	4	0.0%	4	0.0%	3	0.0%
Volunteer Comm Hosp	6	0.0%	2	0.0%	3	0.0%
Jamestown Reg Med Cntr	1	0.0%	3	0.0%	3	0.0%
Roane Med Cntr	6	0.0%	6	0.0%	3	0.0%
Reg Hosp of Jackson	2	0.0%	6	0.0%	3	0.0%
Southern TN Reg Health Sys-Sewane	6	0.0%	2	0.0%	3	0.0%
Reg One Health	6	0.0%	3	0.0%	3	0.0%
Parkridge East Hosp	8	0.0%	4	0.0%	3	0.0%
Starr Reg Med Cntr-Athens	9	0.0%		0.0%	3	0.0%
Med Cntr of Manchester	5	0.0%	1	0.0%	3	0.0%
Saint Thomas Hickman Hosp	3	0.0%	4	0.0%	3	0.0%
Methodist Med Cntr of Oak Ridge	4	0.0%	5	0.0%	3	0.0%
Morristown-Hamblen H-care Sys	2	0.0%	2	0.0%	3	0.0%
Rhea Med Cntr	6	0.0%		0.0%	2	0.0%
Henderson Co Comm Hosp	2	0.0%	2	0.0%	2	0.0%
Methodist North Hosp	1	0.0%	1	0.0%	2	0.0%
Lauderdale Comm Hosp		0.0%		0.0%	2	0.0%
McFarland Hosp	11	0.0%	15	0.0%	2	0.0%
Southern TN Reg Health Sys-Lawren	8	0.0%	6	0.0%	2	0.0%
Tennova H-care-North Knoxville Med	3	0.0%	5	0.0%	2	0.0%
Livingston Reg Hosp	8	0.0%	3	0.0%	2	0.0%
Milan Gen Hosp	1	0.0%		0.0%	2	0.0%
Ft Loudoun Med Cntr	1	0.0%	3	0.0%	2	0.0%
Starr Reg Med Cntr-Etowah	1	0.0%		0.0%	2	0.0%
Tennova H-care-LaFollette Med Cntr	1	0.0%	1	0.0%	2	0.0%
Houston Co Comm Hosp		0.0%	2	0.0%	1	0.0%
Sweetwater Hosp Assn		0.0%	2	0.0%	1	0.0%
Bolivar Gen Hosp, Inc.	3	0.0%	2	0.0%	1	0.0%
Camden Gen Hosp	10	0.0%	4	0.0%	1	0.0%
BMH-Tipton	2	0.0%	2	0.0%	1	0.0%
Copper Basin Med Cntr	2	0.0%	1	0.0%	1	0.0%
Vanderbilt Stallworth Rehab Hosp	1	0.0%		0.0%	1	0.0%
Tennova H-care-Lakeway Reg Hosp	1	0.0%	3	0.0%	1	0.0%
Haywood Park Comm Hosp		0.0%	1	0.0%	1	0.0%
Lincoln Med Cntr	2	0.0%	2	0.0%	1	0.0%
Delta Med Cntr	2	0.0%	5	0.0%	1	0.0%
BMH-Union City		0.0%	2	0.0%	1	0.0%
Parkridge West Hosp	1	0.0%	5	0.0%	1	0.0%
Erlanger North Hosp	4	0.0%	1	0.0%	1	0.0%
Perry Comm Hosp, LLC	6	0.0%	6	0.0%	1	0.0%
Methodist South Hosp	2	0.0%	6	0.0%	1	0.0%
Sycamore Shoals Hosp	1	0.0%	2	0.0%	1	0.0%
Decatur Co Gen Hosp	2	0.0%		0.0%	1	0.0%

SUPPLEMENTAL #1

August 25, 2015

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	2012		2013		2014	
Facility	Visits	%	Visits	%	Visits	%
Johnson Co Comm Hosp		0.0%		0.0%	1	0.0%
Jellico Comm Hosp, Inc.		0.0%	1	0.0%		0.0%
Claiborne Med Cntr	1	0.0%		0.0%		0.0%
Methodist Fayette Hosp		0.0%	1	0.0%		0.0%
Hardin Med Cntr	3	0.0%	2	0.0%		0.0%
Riverview Reg Med Cntr North	47	0.1%		0.0%		0.0%
Laughlin Memorial Hosp, Inc.		0.0%	3	0.0%		0.0%
Indian Path Med Cntr		0.0%	2	0.0%		0.0%
Franklin Woods Comm Hosp	3	0.0%	2	0.0%		0.0%
Le Bonheur Children's Hosp	1	0.0%	5	0.0%		0.0%
Tennova H-care-Newport Med Cntr	2	0.0%	2	0.0%		0.0%
Erlanger Bledsoe	4	0.0%		0.0%		0.0%
McNairy Reg Hosp	5	0.0%		0.0%		0.0%
Wellmont Hancock Co Hosp		0.0%	1	0.0%		0.0%
Pioneer Comm Hosp of Scott		0.0%		0.0%		0.0%
BMH-Huntingdon	1	0.0%		0.0%		0.0%
Humboldt Gen Hosp		0.0%	1	0.0%		0.0%
Gibson Gen Hosp		0.0%	1	0.0%		0.0%

SUPPLEMENTAL #1

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Attachment 4

SUPPLEMENTAL #1

August 25, 2015
2:15 pm

LIFEPOINT
HEALTH

August 24, 2015

Melanie Hill
Executive Director
Tennessee Health Services
And Development Agency
Andrew Jackson, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Sumner Regional Medical Center – Certificate of Need to Open Freestanding Emergency Department

Dear Ms. Hill:

I am the Central Group Chief Financial Officer of LifePoint Health ("LifePoint"), the parent organization of Sumner Regional Medical Center ("SRMC"). This letter confirms that LifePoint will fund the project through available cash reserves at a cost of approximately $5,603,276 for SRMC's project to open a freestanding emergency department at its Sumner Station Campus. LifePoint is committed to make these funds available to SRMC.

Thank you for your attention to this matter.

Very truly yours,

Jonathan C. Wall
Chief Financial Officer, Central Group

330 Seven Springs Way, Brentwood, Tennessee 37027
Phone 615.920.7000

LIFEPOINTHEALTH.NET

SUPPLEMENTAL #1

August 25, 2015

2:15 pm

Attachment 5

SUPPLEMENTAL #1

August 25, 2015
2:15 pm

HIGHPOINT HEALTH SYSTEMS
POLICY/PROCEDURE

SUBJECT: Financial Assistance Program	PAGE #1 OF 2		
	EFFECTIVE DATE: 9/1/2010		
DEPARTMENT: Patient Financial Services		DATE	DATE
APPROVED BY:	_X_ Reviewed _X_ Revised	2/11/2014	
DEPARTMENT DIRECTOR: Beth Lemons			
ADMINISTRATION:	___ Reviewed ___ Revised		
OTHER (Ancillary, Medical Staff):	___ Reviewed ___ Revised		

Purpose:

To outline procedures for determining if an individual or family qualifies for care at a reduced or no cost based on their financial status for HighPoint Health Systems patients. , (Sumner Regional Medical Center, Trousdale Medical Center, and Riverview Regional Medical Center)

Policy:

Eligibility will be determined utilizing the current guidelines at 200% of Federal poverty levels. These guidelines are issued annually by the Federal Government. This procedure will also follow the corporate guidelines as outlined in APG1. Prior to submission for charity consideration, all accounts must be reviewed and the guarantor determined to be non-eligible for financial assistance through any program available in our patient area. If it is determined through this evaluation that the patient meets the guidelines for uncompensated care, complete forgiveness of the debt will be granted, without regard for the patient's sex, race, age, or national origin.

If a patient has Medicare or a Medicare Advantage plan with Medicaid secondary and they have non-covered outpatient self-administered drugs, the amount of the non-covered self-administered drugs can be adjusted off as a charity adjustment. This does not include patients with Medicaid SLMB benefits only.

SUPPLEMENTAL #1

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Procedure:

Hospital representative or third party vendor will perform the following:

- Receive Financial Assistance Application and the Financial Disclosure Form.
- Advise the patient that all information disclosed to HHS will be kept in strict confidence.
- Advise the applicant that they will be required to provide supporting documentation. (Federal tax return for previous year, proof of current income, expenses, etc.)
- Ensure that the applicant's portion of the application is completed and all of the required supporting documentation is attached to the application.
- Approve/Deny application according to established guidelines outlined in Attachment "A". If denied, send appropriate letter of denial to the applicant. If approved, send appropriate approval letter. If greater than PFSD's limit of $5,000, forward to CFO for approval.
- Process the financial assistance adjustment when all proper approvals have been obtained.

Attachment "A"

Federal Charity Guidelines

SUPPLEMENTAL #1

August 25, 2015
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2014

To qualify for the standard charity discount effective January 1st, 2014, the patient's gross annual income must be less than the figure shown for 200% of the poverty level. Local state guidelines may require a different percentage. If the patient/guarantor total family income exceeds the table below, the patient/guarantor does not qualify for a charity discount.

Family Size	Federal Poverty Level	200% Poverty Level
1	$11,670	$23,340
2	$15,730	$31,460
3	$19,790	$39,580
4	$23,850	$47,700
5	$27,910	$55,820
6	$31,970	$63,940
7	$36,030	$72,060
8	$40,090	$80,180

***For family units with more than 8 members, add $4,060 for each additional member to obtain the Poverty Level.**

SUPPLEMENTAL #1

August 25, 2015
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SUMNER
Regional Medical Center
HIGHPOINT HEALTH SYSTEM

As part of its commitment to serve the community, Sumner Regional Medical Center, Trousdale Medical Center, Riverview Regional North & South Medical Centers elects to provide financial assistance to individuals who satisfy certain income and asset requirements.

Before filling out the financial assistance form, you must have proof from the Marketplace Healthcare enrollment that you have wither been accepted or rejected. This is a requirement that must be obtained in order to qualify for financial assistance at our Facilities.

Please complete the application and provide all the requested documentation (**required documentation listed on the application**). **The application must be returned to Patient Financial Services within five (5) business days.** You will continue to receive statements and attempts to collect this debt while the application is in review. Once the application has been reviewed by the financial counselor a letter will be sent out advising you of the decision.

Any consideration or potential approval of charity assistance applies **ONLY** to services provided by Sumner Regional, Trousdale Medical and Riverview Regional North & South Medical Centers and is not related or applied anyway to any physician bills whether by your attending physician or any consulting, pathologist, radiologist or any other physician which may be involved in your care.

If you need assistance in making copies or filling out the application, please feel free to contact Financial Counselor **Stephanie Biggs at 615-328-6615.** Office hours are Monday through Friday, 8:00-4:30. Please return the application to the mailing address listed below:

HighPoint Health Systems
P.O. Box 1558
Gallatin, TN 37066

We sincerely hope to be of assistance to you.

Patient Financial Services

SUPPLEMENTAL #1

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FINANCIAL ASSISTANCE APPLICATION

Applicant's Name: ______________________________ Spouse/Partner: ________________________

Social Security #:_____________________________ Birthdate: _______________________________

Address: ____

Daytime phone #: _________________________ other #____________________________

Employer: _________________________________ how long employed: ____________________

Spouse Employer: ___________________________ how long employed: ____________________

Names of other individuals under the age of 18 living in the household:

_______________________________________ ___________________________________

WAGES: Annual Salary $__________________Monthly Salary $____________________

Hourly Rate $____________ Avg. Hours per Week _____________

***Income Verification**: Please provide proof of income on anyone who is working in the household.*

Tax Return – with W-2's	*Proof of government assistance program such as food stamp.*
Paycheck stub	*Social Security*
Disability income	*Unemployment income*

***Proof of Healthcare exchange online enrollment (if this is not provided you will not be considered for charity)**

If you are not working please provide a written explanation as to your situation and if you are living with someone provide a statement from that person.

Do you own or have mo. Mortgage _____ Yes _____ no Amt. owed$_______ Mo. Payment $__________

Do you rent your home? _____ Yes _____ no If yes, monthly payment $________________

Do you own an automobile? _____ Yes _____ no If yes, monthly payment $________________

Monthly household expenses including utilities, loans, insurance, credit cards, etc. (please provide copies of each household expense)

Total monthly expenses $____________ Total owed to other medical providers $____________

Checking account balance: $__________ saving account balance: $______________

I certify that the information given on this application is true and correct to the best of my knowledge. I authorize SRHS to obtain information from external reporting agencies.

____

Signature of Applicant/Guarantor **Date**

SUPPLEMENTAL #1
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Attachment 6

SUPPLEMENTAL #1

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SATELLITE ED ONLY
PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in January. (Numbers reported in thousands)

		Year 1 7/17-6/18	Year 2 7/18-6/19
A.	Utilization Data (Admissions)	5,789	5,992
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services		
	3. Emergency Services	$18,223	$19,145
	4. Other Operating Revenue (Specify)		
	Gross Operating Revenue	$18,223	$19,145
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$12,592	$13,252
	2. Provision for Charity Care	$120	$130
	3. Provisions for Bad Debt	$2,067	$2,167
	Total Deductions	$14,779	$15,549
NET OPERATING REVENUE		$3,444	$3,596
D.	Operating Expenses		
	1. Salaries and Wages	$686	$704
	2. Physician's Salaries and Wages		
	3. Supplies	$365	$391
	4. Taxes	631	667
	5. Depreciation	$250	$250
	6. Rent		
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		

SUPPLEMENTAL #1

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9. Other Expenses (See details below)	$524	$541
Total Operating Expenses	$2,456	$2,553
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	$987	$1,043
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$987	$1,043

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 1 7/17-6/18	Year 2 7/18-6/19
1. E/R Physician Coverage Subsidy	$255	$263
2. Information Systems Fees	$231	$238
3. Repairs & Maintenance	$38	$40
4.		
5.		
6.		
7.		
Total Other Expenses	**$524**	**$541**

SUPPLEMENTAL #1

August 25, 2015

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Attachment 7

SUPPLEMENTAL #1

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MAIN HOSPITAL ED
HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January. (Numbers reported in thousands)

		2012	2013	2014
A.	Utilization Data (ER Visits)	37,193	38,403	37,147
B.	Revenue from Services to Patients			
	1. Inpatient Services			
	2. Outpatient Services			
	3. Emergency Services	$78,129	$102,802	$136,366
	4. Other Operating Revenue (Specify) - Misc.			
	Gross Operating Revenue	$78,129	$102,802	$136,366
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$48,588	$68,691	$97,242
	2. Provision for Charity Care	$444	$623	$874
	3. Provisions for Bad Debt	$7,994	$11,301	$15,999
	Total Deductions	$57,026	$80,616	$114,115
NET OPERATING REVENUE		$21,103	$22,186	$22,250
D.	Operating Expenses			
	1. Salaries and Wages	$2,843	$3,089	$3,088
	2. Physician's Salaries and Wages			
	3. Supplies	$1,488	$1,536	$1,486
	4. Taxes	$6,254	$6,517	$6,540
	5. Depreciation			
	6. Rent			
	7. Interest, other than Capital			
	8. Management Fees:			
	a. Fees to Affiliates			
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	$738	$851	$907

SUPPLEMENTAL #1

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Total Operating Expenses	$11,322	$11,993	$12,021
E. Other Revenue (Expenses) - Net (Specify)			
NET OPERATING INCOME (LOSS)	$9,781	$10,193	$10,229
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$9,781	$10,193	$10,229

Detail of Other Expenses

Profees (Physician ER Group stipend)	$699	$745	$755
IT&S	$10	$78	$103
Repairs & Maintenence	$21	$23	$30
Other (Training and Education, Travel, etc...)	$8	$5	$19
Total	$738	$851	$907

SUPPLEMENTAL #1

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Attachment 8

SUPPLEMENTAL #1

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MAIN HOSPITAL ED ONLY
PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in January. (Numbers reported in thousands)

		Year 1 7/17-6/18	Year 2 7/18-6/19
A.	Utilization Data (ER Visits)	35,453	36,694
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services		
	3. Emergency Services	$111,602	$117,242
	4. Other Operating Revenue (Specify)		
	Gross Operating Revenue	$111,602	$117,242
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$77,116	$81,156
	2. Provision for Charity Care	$700	$750
	3. Provisions for Bad Debt	$12,692	$13,319
	Total Deductions	$90,508	$95,225
NET OPERATING REVENUE		$21,095	$22,016
D.	Operating Expenses		
	1. Salaries and Wages	$3,114	$3,223
	2. Physician's Salaries and Wages		
	3. Supplies	$1,418	$1,468
	4. Taxes	6,105	6,403
	5. Depreciation		
	6. Rent		
	7. Interest, other than Capital		
	8. Management Fees: a. Fees to Affiliates		
	b. Fees to Non-Affiliates		

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9. Other Expenses (See details below)		$908	$908
	Total Operating Expenses	$11,545	$12,002
E. Other Revenue (Expenses) -- Net (Specify)			
NET OPERATING INCOME (LOSS)		$9,549	$10,015
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
	Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$9,549	$10,015

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES		Year 1 7/17-6/18	Year 2 7/18-6/19
1.	Profees (Physician ER Group stipend)	$755	$755
2.	IT&S	$103	$103
3.	Repairs & Maintenence	$30	$30
4.	Other (Training and Education, Travel, etc...)	$20	$20
5.			
6.			
7.			
	Total Other Expenses	**$908**	**$908**

SUPPLEMENTAL #1

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Attachment 9

SUPPLEMENTAL #1
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HOSPITAL WIDE
PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in January. (Numbers reported in thousands)

		Fiscal Yr 2017	Fiscal Yr 2018
A.	Utilization Data (Adj Admits)	18,018	18,739
B.	Revenue from Services to Patients		
	1. Inpatient Services	$310,032	$319,845
	2. Outpatient Services	$219,759	$226,170
	3. Emergency Services	$141,934	$152,579
	4. Other Operating Revenue (Specify)	$2,598	$2,650
	Gross Operating Revenue	$674,323	$701,244
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$514,715	$536,334
	2. Provision for Charity Care	$6,459	$6,730
	3. Provisions for Bad Debt	$19,850	$20,684
	Total Deductions	$541,024	$563,748
NET OPERATING REVENUE		$133,299	$137,496
D.	Operating Expenses		
	1. Salaries and Wages	$57,774	$58,558
	2. Physician's Salaries and Wages	4,200	6,200
	3. Supplies	$18,289	$18,654
	4. Taxes	9,801	9,927
	5. Depreciation	$9,150	$9,600
	6. Rent	$1,446	$1,475
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates	5,000	5,000
	b. Fees to Non-Affiliates		
	9. Other Expenses (See details below)	$22,370	$22,818

SUPPLEMENTAL #1

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Total Operating Expenses	$128,030	$132,232
E. Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)	$5,269	$5,264
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$5,269	$5,264

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES		**Year 2017**	**Year 2018**
1.	Professional Fees	$6,087	$6,209
2.	Contract Services	$7,189	$7,333
3.	Repairs & Maintenance	$3,926	$4,005
4.	Utilities	$3,202	$3,266
5.	Other Operating	$1,152	$1,175
6.	Insurance	$814	$830
7.			
	Total Other Expenses	**$22,370**	**$22,818**

SUPPLEMENTAL #1

August 25, 2015

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Attachment 10

AUG 25 '15 PM 2:15

SUPPLEMENTAL #1
August 25, 2015
2:15 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Sumner

NAME OF FACILITY: Sumner Regional Medical Center_______________

I, Michael Herman, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

COO

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 21st day of August, 20 15, witness my hand at office in the County of Sumner, State of Tennessee.

NOTARY PUBLIC

My commission expires October 23, 2018.

HF-0043

Revised 7/02

LISA R. WEBB
STATE OF TENNESSEE NOTARY PUBLIC
SUMNER COUNTY
My Commission Expires October 23, 2018

Supplemental #2
-COPY-

Sumner Regional Medical Center (Satellite Emergency Dept)

CN1508-029

SUPPLEMENTAL

August 28, 2015

Via Hand Delivery

Mr. Phillip Earhart
Health Services Development Examiner
Health Services Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

RE: Certificate of Need Application CN1508-029
Sumner Regional Medical Center (Satellite Emergency Department)

Dear Mr. Earhart:

Thank you for acknowledging receipt of our August 25, 2015 supplemental response for a Certificate of Need to establish a full service, 24 hour per day/7 day per week satellite emergency department. The proposed satellite emergency department is planned to be located at Sumer Regional Medical Center's existing outpatient facility known as Sumner Station located at 225 Big Station Camp Boulevard, Gallatin (Sumner County).

We received your request for supplemental information on August 28th. **Our responses, below, are provided in triplicate by the deadline of 12PM, Monday August 31, 2015.**

---

1. **Section C, Need, Item 4.A. and 4.B.**

   Your response to this item is noted. Using population data, please complete the following table and include data for each zip code in your proposed service area. If needed, 2010 ZIP Code data is available at the following US Census web address http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtmlbelow The following table may need to be modified by year to reflect the most current available population data.

   Response: Please see the completed table below. Population data by zip code is included for 2015 and 2020 from leading demographic provider, Nielsen Claritas.

Variable	*Zip Code 37066*	*Zip Code 37075*
Current Year (CY), Age 65+	***7,606***	***9,518***
Projected Year (PY), Age 65+	***9,341***	***11,679***
Age 65+, % Change	***22.8%***	***22.7%***
Age 65+, % Total (PY)	***18.4%***	***17.4%***
CY, Total Population	***47,157***	***63,055***
PY, Total Population	***50,795***	***67,031***
Total Pop. % Change	***7.7%***	***6.3%***
TennCare Enrollees	***n/a***	***n/a***
TennCare Enrollees as a % of Total Population	***n/a***	***n/a***
Median Age	***38.4***	***39.0***
Median Household Income	***$49,632***	***$63,464***
Population % Below Poverty Level	***12.9%***	***8.7%***

2. Section C. Economic Feasibility Item 1 (Project Cost Chart)

There must be an assessment of the space being used as the emergency department in the Project Cost Chart. It should reflect the fair market value of the space, or if applicable the lease cost over the life of the lease, whichever is higher. Also even if applicant has already paid for property/space, the applicant will need to assess the fair market value of the property/space and include it in Project Cost Chart unless it has been accounted for in a previously approved CON application. If applicable, please revise the Project Costs Chart. If there is an increase in the CON filing fee, please submit.

Response: The fair market value of the existing shell building at Sumner Station was recently determined to be approximately $144.48 per square foot. Therefore, the cost attributed to the proposed 10,210 square foot satellite ED is $1,475,159 (allowing for rounding). Please see **Attachment 1** for the revised Project Cost Chart.

The additional filing fee is calculated at a rate of $2.25/$1,000 of additional project cost. Therefore, an additional check in the amount of $3,319.11 is enclosed with this information.

SUPPLEMENTAL

We hope these responses are sufficient to deem this CON application complete. A notarized affidavit is provided in **Attachment 2**.

I may be reached by phone at 615-328-6695 or by email at Michael.Herman@LPNT.net to clarify any other matters.

Sincerely,

Michael Herman
Chief Operating Officer
Sumner Regional Medical Center

Attachments

Attachment 1

SUPPLEMENTAL

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$352,800
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$100,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs	$2,940,000
6.	Contingency Fund (Owner's Contingency)	$294,000
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment	$1,227,697
9.	Other	$676,200
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	1,475,159
2.	Building only	
3.	Land only	
4.	Equipment (Specify) ________________	
5.	Other (Specify) ________________	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	
D.	Estimated Project Cost (A+B+C)	$7,065,856
E.	CON Filing Fee	$15,898
F.	Total Estimated Project Cost (D+E)	$7,081,754
	TOTAL	$7,081,754

Attachment 2

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Sumner

SUPPLEMENTAL

NAME OF FACILITY: Sumner Regional Medical Center

I, Michael Herman, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

COO
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of August, 2015, witness my hand at office in the County of Sumner, State of Tennessee.

Lisa R Webb
NOTARY PUBLIC

My commission expires October 23, 2018.

HF-0043

Revised 7/02

LISA R. WEBB STATE OF TENNESSEE NOTARY PUBLIC SUMNER COUNTY My Commission Expires October 23, 2018

SUPPLEMENTAL

1003

SUMNER REGIONAL MEDICAL CENTER
555 HARTSVILLE PIKE
GALLATIN, TENNESSEE 37066

DATE 08-28-15   64-10-610

Pay to the order of TN Health Services + Development Agency $ 3,319.11

Three thousand three hundred nineteen + 11/100 ——— DOLLARS

SUNTRUST   ACH RT 061000104

FOR CON Filing Fee   S. Bost Susan Peach

⑈0000 1003⑈ ⑆061000104⑆ 1000187147326⑈